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### RHEUMATOID ARTHRITIS AFTER INJURY TO A SINGLE JOINT.

By MICHAEL KELLY,  
Melbourne.

BRUGIÈRE<sup>(1)</sup> in 1817 was the first to discuss the relation of injury to acute rheumatism. In 1912 Deveau<sup>(2)</sup> reported 38 cases, and laid down the doctrine that injury sometimes was the sole visible factor in the causation of acute rheumatism. Recently Sangster<sup>(3)</sup> reported cases in which the first attack of rheumatic fever was precipitated by injury to a single joint. Glazebrook and Thomson<sup>(4)</sup> found trauma to be responsible for 11 out of 115 cases of acute rheumatism. Lately Stern<sup>(5)</sup> has fully reviewed the subject and reemphasized the reality of the relationship; and Rosenblatt<sup>(6)</sup> has reported cases in the United States Army.

Injury is recognized, of course, as a cause of osteoarthritis. But chronic polyarthritis is another matter. Pemberton and Peirce<sup>(7)</sup> thought that injuries of different kinds precipitated chronic arthritis in 56 out of 632 cases.

Smith's proportion was 11 out of 102, and in six of these a single joint was sprained.<sup>(8)</sup> Matz<sup>(9)</sup> listed trauma as a cause in 78 out of 266 cases of chronic arthritis; some of these, he said, were cases of polyarthritis. Campbell<sup>(10)</sup> agreed that injury could be a cause, and commented on its medico-legal implications. Several European writers<sup>(11)</sup> discussed the question during the years from 1930 to 1937. Most of them accepted Klinge's view<sup>(12)</sup> that allergy was the basic cause, the antigen being the autolytic products of the damaged tissues.

More recently Edström<sup>(13)</sup> reviewed nineteen cases of chronic rheumatism associated with trauma, in six of which damage to a single joint was the only visible cause; but the main factor in all, he thought, was an underlying "hyperergic" state. Ryden<sup>(14)</sup> insisted upon the fulfilment of the following three criteria before he could agree that trauma was the cause: (i) onset of arthritis promptly following the injury; (ii) no remission in the injured joint

before the onset of symptoms in other joints; (iii) the injured joint being the first to develop arthritis. To these a fourth condition should be added, which Ryden implied but did not state: there should have been no previous history of rheumatic joint disease. Out of nearly 1000 cases reviewed, Ryden was able to find nineteen that fulfilled his conditions.

A. H. Douthwaite,<sup>(15)</sup> commenting on Ryden's data, regards the role of trauma as "debatable"; like Ryden himself, he lays stress on other factors such as focal sepsis. Ryden claimed to have found evidence of gross focal infection in fifteen of his nineteen cases; but his evidence is not wholly convincing. Nearly all the writers upon this subject seem anxious to be relieved of the burden of explaining the arthritis wholly as the result of the trauma. Ropes and Bauer<sup>(16)</sup> will not accept it if the onset of the arthritis has been delayed more than twelve hours after the injury. Finney, Boland and Hench<sup>(17)</sup> recorded that monarticular trauma precipitated an initial attack or a relapse of rheumatoid arthritis in five out of 100 cases in soldiers.

#### Reports of Cases.

In the following ten cases there was no rheumatic history before the precipitation of chronic polyarthritis by injury to a single joint.

CASE I.—An army sister, aged twenty-eight years, mildly sprained her left wrist, which remained painful and stiff for several months. Fracture of the navicular bone was excluded by X-ray examination. The pain in the wrist then subsided, but the shoulders, elbows, knees and ankles became painful and stiff for varying periods. Two years after the original injury she was incapacitated, with pain, stiffness and intermittent swelling of the right knee, and pain on weight-bearing in the right metatarsal region.

CASE II.—A man, aged fifty-five years, sprained his right ankle, which remained painful and swollen. A few weeks later the left ankle swelled and became painful. A year later the condition of the ankles was the same; the metacarpophalangeal joints of the right hand were swollen, and intermittent pains were felt in both wrists, in the left elbow and in the right shoulder.

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CASE III.—A woman, aged fifty-nine years, ran nearly a mile to catch a train. While she was sitting in the train the right knee swelled and became painful, so that she could not rise out of her seat. The knee remained swollen, and some months afterwards her shoulders and neck became painful, and the left knee swelled a little. Two years later the fingers were affected. Neither the ankles nor the feet have been affected, though the disease has been in progress for eight years.

CASE IV.—A female patient fell and hurt her left foot, which swelled so that she was incapacitated for some weeks. After three months the joints of the right hand swelled. During the next few years every joint was affected, and after fourteen years the wrists, fingers and feet were the most seriously involved, with deformity.

CASE V.—A woman, aged sixty years, twisted her left knee, which swelled, and she spent a week in bed. The knee recovered completely, but the wrists became stiff, painful and slightly swollen. Five months after the original injury both ankles swelled.

CASE VI.—A woman, aged seventy-one years, fell and injured her right leg. The knee was swollen and painful, and remained so. After six months the left knee swelled. A year after the injury both knees were grossly affected, with hypertrophy of the synovial membrane, distension of the joints, enlargement and rarefaction of the bone ends, and flexion deformity. Many of the digital joints, and both wrist joints, were also affected.

CASE VII.—A man, aged forty-two years, a sufferer from chronic bronchitis, knocked the proximal interphalangeal joints of his left index finger, damaging the skin. Three days later the joint swelled, and a few days later the left distal radio-ulnar joint swelled. A week later the right elbow became painful, and next the feet became sore. Eventually he had a severe attack of polyarthritis. Now, at the age of fifty-six years, his main trouble is in his elbows, wrists and fingers.

CASE VIII.—A man, aged thirty years, fell when "lumping" a bale of wool, and finished in a kneeling position with the bale resting on his right calf. He sustained a wound of the right shin, which had to be sutured. Next day the right knee swelled, and the swelling subsided within two weeks. He returned to work on the wharf, but the knee kept swelling and subsiding, and after six weeks he left the job. The left knee then swelled, and then the heels and the metatarsal heads of both feet became sore. He developed severe periarthritis of the left shoulder, with fixation in adduction.

CASE IX.—A soldier's left knee swelled after a knock. After the swelling had subsided, the knee remained stiff and painful. Two months later the right knee became stiff and painful, and on examination both knees displayed crepitus. After a further six weeks the fingers of both hands were painful, and there was tenderness beneath the right heel which caused difficulty in walking. The soldier was discharged from the army, and his later history is unknown.

CASE X.—Corporal A.P. had sustained in childhood a compound comminuted fracture of his right patella, which left a huge scar and irregularity of bone. Eighteen years later he fell and twisted the right knee, which swelled. Soon there was pain in the left wrist; then the left knee swelled, and all the joints became stiff and painful. He was unfit for duty for seven months, and on his return to his unit he complained only of a painful heel.

Case X was not strictly one of rheumatoid arthritis, but rather of an intractable acute polyarthritis. Case IX could be described more accurately, perhaps, as one of multiple periarticular fibrositis. But in each case the line of demarcation is indistinct.

#### Spread of Disease: Symmetry.

When rheumatoid arthritis follows injury to a joint, we are provided with a human experiment in which the disease begins in a certain joint in response to a known stimulus, and spreads in a regular manner to other joints. The order of invasion, in 34 cases in which data are provided, is shown in Table I.

In 13 out of 34 cases the second joint involved was the opposite fellow of the injured one, and in five others the opposite joint was involved early. In at least ten of the remainder the second manifestation of rheumatic disease was its simultaneous appearance in two symmetrical joints (both ankles, both wrists *et cetera*).

The orthodox view holds that rheumatoid arthritis, being a constitutional disorder, would have developed in these

patients whether or no they had sustained the injuries. But I am tempted to wonder whether this view is correct. It is customary to assume that the patients have always been predisposed to the disease; but of this we have no evidence except the bare fact that they acquired the disease. To argue thus after the event is to commit an error in logic. Of constitutional factors that predispose to rheumatism we know nothing, apart from the fact that it sometimes afflicts several members of a family.

TABLE I.  
Order of Early Involvement of Joints in 34 Cases.

Series.	Case Number.	Part Injured.	Second Joint Involved.
Ryden.	I	Right hand.	Left hip.
	II	Right foot.	Left foot.
	III	Left foot.	Right foot.
	IV	Right elbow.	Left elbow.
	V	Right knee.	Both ankles.
	VI	Left knee.	Left ankle.
	VII	Right knee.	Left knee.
	VIII	Right foot.	Right knee, left foot.
	IX	Left hand.	Left ankle, right wrist.
	X	Left wrist.	Right wrist.
	XI	Right knee.	Both groins, left knee.
	XII	Right foot.	Left foot.
	XIII	Right hand.	Right hip.
	XIV	Right wrist.	Right shoulder.
	XV	Left foot.	Both wrists.
	XVI	Left knee.	Both wrists.
	XVII	Right knee.	Both wrists.
	XVIII	Right foot.	Both wrists.
	XIX	Left knee.	Both wrists.
Edström.	V	Right hand.	Right wrist.
	IX	Knee.	Opposite knee.
	X	Right wrist.	Left wrist.
Ropes and Bauer.		Left ankle.	Left ankle.
		Left knee.	Left ankle.
		Left ankle.	Left ankle.
Present Series.	I	Left wrist.	Both shoulders.
	II	Right ankle.	Left ankle.
	III	Right knee.	Both shoulders, left knee.
	IV	Left foot.	Right hand.
	V	Left knee.	Both wrists.
	VI	Right knee.	Left knee.
	VII	Left hand.	Left wrist.
	VIII	Right knee.	Left knee.
	IX	Left knee.	Right knee.
	X	Right knee.	Left wrist, left knee.

Four of the ten patients had passed the age of fifty-five years before meeting with the accident that brought on the disease. The patient in Case VI lived for seventy-one years without rheumatism, and it hardly seems reasonable to assume that she was hiding somewhere a constitutional predisposition. Perhaps it is more correct to state that the accident found her in a state especially favourable to the spread of the disease process. But this especially favourable state is not of necessity a permanent constitutional defect; perhaps it was only a transient state of receptiveness that allowed the disorder to become firmly established.

Thus it may be that the onset of rheumatoid arthritis is the result of a train of accidental circumstances that favour its establishment.

#### Summary.

1. Monarticular trauma sometimes is the only visible causative factor in rheumatoid arthritis.
2. In its spread the disease shows a striking preference for symmetrical patterns.
3. The constitutional factor that favours the spread of the disease, it is suggested, is a transient rather than a permanent condition of the organism.

#### Acknowledgements.

My thanks are due to Dr. Reginald Howden for permission to report cases from the arthritis clinic of the Royal Melbourne Hospital, and to the Director-General of Medical Services for permission to report army cases.

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## CONGENITAL CYSTIC DISEASE OF THE LUNG.

By K. M. BOWDEN,

Stewart Lecturer in Pathology and Lecturer in Forensic Medicine, University of Melbourne;  
Pathologist to the City Coroner,  
Melbourne.

THIS paper is based on a post-mortem study of twenty cases of congenital cystic disease of the lung found at autopsy during the past five years.

The condition was described over three hundred years ago by Fontanus in a baby three months old. In 1925 Koontz<sup>(1)</sup> reported a case in a twelve days old male child, and tabulated 103 other cases which he gathered from the medical literature. It is interesting to note that nearly all these cases were reported in the German literature, although there were some from English, French and Italian sources. No American cases were found. In 1936 Schenck<sup>(2)</sup> reported a series of four cases, and in addition to those collected by Koontz gathered together a further 124 cases from all over the world; over half of these cases emanated from the United States. That over sixty cases should have been reported in the American literature in eleven years, and that none had been reported prior to 1925, was evidence of the attention drawn to the subject by the previous paper of Koontz.

There is much confusion in the terminology. Foetal bronchiectasis, atelectatic bronchiectasis, bronchioectasis, congenital bronchiectasis, cystic malformation, polycystic lung and honeycomb lung are various names that have

been applied, indicating different interpretations by different writers of the nature and origin of this condition.

Congenital cystic disease of the lung is a definite pathological entity, distinct from bronchiectasis, which may itself be congenital or acquired. However, there are many borderline cases which, particularly from the radiological

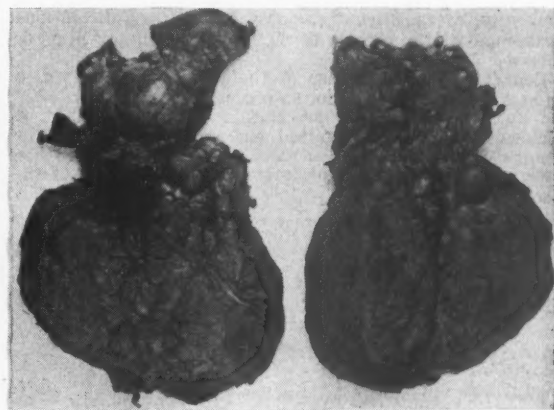


FIGURE I.

Photograph of both lungs, showing innumerable cysts projecting on the pleural surfaces.

standpoint, are difficult to assign to their correct category as either congenital cystic disease of the lung or bronchiectasis. Bronchiectasis and congenital cystic disease are frequently present together in the same lung. There were seven cases in this series of twenty in which macro-



FIGURE II.

A post-mortem X-ray picture of a lung, showing a subpleural cyst filled with barium. The bronchus running into the cyst wall is shown full of barium.

scopically bronchiectasis was a distinct feature apart from the presence of the congenital cysts. This is not a mere academic distinction, because there are many cases of cystic disease without bronchiectasis, recognizable as such, and cases of congenital bronchiectasis without cyst formation. There are writers who are prepared to admit that



the cystic condition is congenital, but who feel doubtful about the accompanying bronchiectasis, preferring to leave open the decision as to whether the bronchiectasis is congenital or acquired. In the earliest case in this series, that of a premature infant of seven months, who lived for one hour, there was an undoubted dilatation of the bronchi and bronchioles that could only have been developmental in origin. It seems that congenital bronchiectasis and congenital cystic disease are only different manifestations of one underlying process in the lung—namely, agenesis or arrested development.

Congenital cystic disease of the lung is usually stated to be a rarity, but it is not so uncommon as we have been led to believe. It is not easy to determine its true incidence. Lenk<sup>(9)</sup> recognized six cases in 10,000 radiographs of the chest. Five cases in this series were discovered at 700 autopsies performed at the direction of the coroner in cases of sudden or unexplained death due to natural or unnatural causes, in which special attention was directed to the examination of the lungs. Unless one is on the watch, the condition may be overlooked at the autopsy.

Males and females are equally affected at any age period; this observation covers the whole span of existence from premature stillbirth to old age. The condition appears to be fairly evenly distributed with regard to age, apart from the first year of life. In the cases tabulated by Koontz ten occurred in premature fetuses or in stillborn fetuses, twenty-nine occurred in the first year of life, fifteen in the first decade, six in the second decade, eight in the third decade, six in the fourth decade, ten in the fifth decade, twelve in the sixth decade, and eight in the seventh decade. There was one case in the ninth decade. This age distribution is paralleled by the twenty cases in the present series, in which the youngest was a seven-months fetus, and the oldest was a male, aged eighty years, who died of a pontine hæmorrhage; of the remainder, six of the cases occurred in the first decade, two in the second, one in the third, two in each succeeding decade up to and including the seventh, and none in the eighth.

That the cystic condition is developmental in origin is strongly supported by the fact that it is found in the fetus, in stillborn infants, and in children who die in early infancy. One child in this series lived fourteen days, and another lived until the age of fifteen months.

Koontz makes the interesting observation that congenital cystic disease of the lungs is not confined to man, but is also found in animals. He cites three cases of other observers, in which rudimentary lobes were found in cattle, the lobes having the characters of bronchiectasis and lung cysts.

Other developmental defects were found in some of the present series of cases. In the premature seven-months

fetus there was no right lung; in the child of fifteen months the right lung was also absent, and there was a rudimentary bud at the usual site of bifurcation of the trachea. In one case congenital fibrocystic disease of the pancreas was present. In another case, that of a youth, aged eighteen years, bilateral cysts, bronchiectasis, a horse-shoe kidney, an undescending testis and gross scoliosis were present. In the literature many associated developmental defects have been described; defects of organs developed from the primitive foregut have been encountered fairly often. Congenital heart disease was not uncommon.

Congenital cysts may be situated anywhere in the lungs. The abnormality may be unilateral or bilateral; it may be confined to portion of a lobe, or may affect a whole lobe, or the whole of one or both lungs. Sometimes the cysts are apical in situation, and may during life give rise to considerable difficulty in differentiating tuberculosis. In

three of these twenty cases cysts were present only in the apical region, and in fourteen of the cases the cysts were distributed through both lungs; there is no special predilection for either lung.

There are two macroscopic forms of congenital cystic disease. Either the condition is represented by one large cyst, the solitary cyst, or else multitudinous tiny cysts are present. The latter type is much more common than the solitary cyst. In two of the cases the condition was represented by one large cyst; the remainder of this series belonged to the multiple small cyst variety. The cysts vary a great deal in size. They may be very small, and although numerous, may escape radiological detection. On the other hand, a whole lobe may be replaced by one large cyst, or a whole lung may be replaced by a large cyst which fills half the thorax and

sometimes encroaches on the opposite side. When the lung is riddled with tiny cysts, the malformation is sometimes described as honeycomb lung.

Subpleural cysts may be conspicuous, and the surface of the lung may be studded with blebs which look like emphysematous bullæ. This is shown in Figure I, which is a photograph of the lungs of a man, aged fifty years, who died of cardiac failure. Numerous subpleural cysts are scattered over both lungs, which on section were found to contain myriads of cysts throughout their substance, with considerable variation in size. One of the subpleural cysts is shown in Figure II—it has been filled with a solution of barium introduced through the main bronchus *post mortem*. The bronchus leading to this cyst is clearly shown in this case; it enters the cyst wall close to the pleura and runs in the wall of the cyst on the pleural surface. Emphysematous bullæ do not open directly into bronchi in this fashion.

Subpleural congenital cysts may rupture and give rise to spontaneous pneumothorax. This happened in one case,

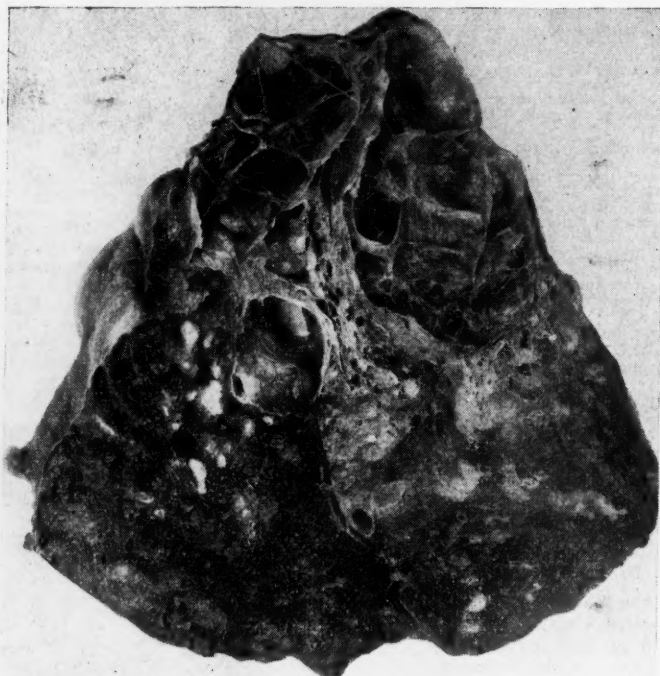


FIGURE III.

A photograph of a section through one of the lungs illustrated in Figure I. The whole lung is riddled with epithelium-lined cysts of varying size. Interlacing filamentous strands of tissue are evident in the upper cysts.



the subject being an elderly female who soon succumbed to the accumulating air in the pleural cavity. The pneumothorax was thought to be due to tuberculosis in life. Before rupture of the cyst there had been no symptoms of pulmonary disease.

Oechsli and Miles<sup>40</sup> described a case of simultaneous bilateral spontaneous pneumothorax in a male, aged twenty-two years; bilateral collapse occurred twice, and unilateral collapse once, each time with complete reexpansion.

Rupture of a subpleural congenital cyst should be kept in mind in the search for the source of a spontaneous pneumothorax, particularly when no other cause can be found in the lung. Congenital subpleural cysts, particularly when they are very small, may not be easily detectable radiologically.

Some of the macroscopic features of congenital cystic disease are illustrated in Figures I, II, III, IV, V and VI.

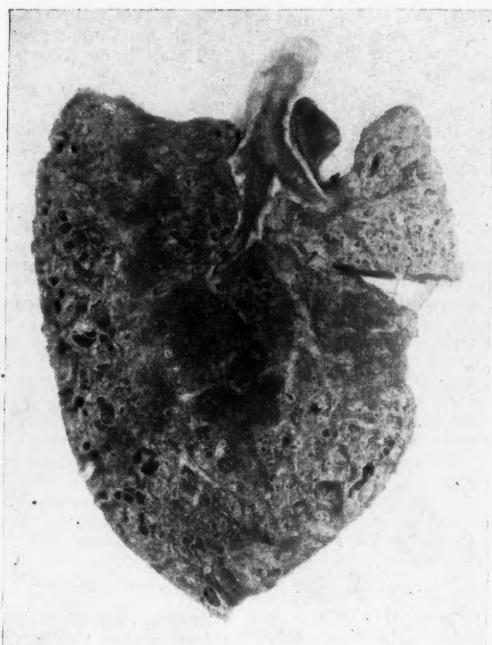


FIGURE IV.

Photograph of a section through the lung of a child; multitudinous cysts, all small. Note the lack of pigmentation in the right upper portion of the section.

In Figures III, IV and V the greater part of the lung is replaced by cysts of various size, and there is little lung tissue of a normal character present between the cystic areas. The cut surface of the lung may be pink and fleshy and devoid of carbon deposits. The pale, white-looking area at the upper right portion of Figure IV shows this feature well, and is the subject of further comment. Some degree of bronchiectasis is also evident in Figures III and V. The cysts are smooth-walled and epithelium-lined. Many of them are communicating directly with bronchi; this is evident in the lower right portion of Figure IV. Many cysts do not show bronchial openings, but this can be decided only by microscopic examination of serial sections. The larger cysts in Figure III show many interlacing filamentous strands, which on microscopic examination are seen to consist of connective tissue lined by cuboidal epithelium. The walls of the cysts vary much in thickness; some are thin, others thick by comparison, particularly if much infection has been present. Figure VI represents a solitary cyst in the right lung, which has been hardened in formalin. In life it was a large, infected, epithelialized cyst which failed to diminish in size despite

adequate and prolonged surgical drainage. This cyst became infected after an operation on the mouth. In the wall of the cyst microscopic examination revealed many mucus-secreting glands. The left lung showed radiological evidence of arrested development of the bronchial tree, and a series of small abortive bronchioles with expanded terminations was attached to the main lower lobe bronchus.

The contents of congenital cysts vary. The majority contain air. Others contain a jelly-like substance which is red or dark in colour. The contents may be fluid and rich in albumin with contained desquamated cells from the lining epithelium. If the cysts have been infected, the contents may consist of pus, mucus and other debris.



FIGURE V.

Section through portion of the lung of an old man, dead of pontine hæmorrhage. Both lungs were like this throughout. There are numerous small cysts and some large cysts in the upper left part of the section. Bronchiectasis is also a pronounced feature.

The intervening lung tissue may be normal, it may be emphysematous, or it may have been considerably modified by previous infection.

#### Histopathology.

Two types of cyst are seen: (i) cysts with bronchial, bronchiolar or atrial derivatives in the wall, according to the level of origin; with such origin they may contain smooth muscle and occasionally cartilage and glands; (ii) cystic spaces with flattened lining morphologically resembling lymphatic spaces.

In many cases congenital cystic disease of the lung becomes infected during life, and this leads to difficulty

in the microscopic interpretation of the basic lesion. Some of the lungs in the present series were uninfected and offered good opportunities for microscopic study. The premature child, the child of two weeks, and the child of fifteen months who died suddenly of cardiac failure, showed no evidence of any previous inflammation in the lungs. In another case, that of a youth, aged twenty-two years, death also occurred from cardiac failure; this case, together with that of the woman who died from a pneumothorax, with two other cases of men aged forty-five years and fifty years respectively who died from cardiac failure, with that of a man who died from carcinoma of the lung, and with that of the elderly man who died from pontine hæmorrhage, made possible a study of the condition in adults' lungs unspoiled by infection. In all the remaining cases heavy infection had occurred; nevertheless the basic pattern even in these subjects was distinguishable, and was essentially the same as in the subjects who died early in



FIGURE VI.

A large solitary cyst in the right lung of a formalin-hardened specimen.

life, and in the uninfected adult subjects. All the cases have much in common, although there are all sorts of variations.

#### Epithelium.

Congenital cysts are epithelium lined, characteristically by epithelium bronchial in type. This is illustrated in Figures VII and VIII, in which ciliated pseudo-stratified epithelium with mucus-secreting cells is evident. Figure VII is a photomicrograph prepared from the seven-months fetus; the epithelium lining the cyst stands on a well-defined basement membrane supported by a little connective tissue. There is a layer of smooth muscle in the wall. In Figure VIII, which is a photomicrograph prepared from the lung illustrated in Figure V, portions of three adjacent cysts are shown around an intervening artery. The cysts are lined with bronchial epithelium, and smooth muscle fibres lie beneath the basement membrane. A different picture is seen in Figure IX, which is a photomicrograph prepared from the lung shown in Figure IV; here the lining epithelium is cuboidal.

Sometimes cystic spaces are found lined by flattened epithelium, and the spaces appear morphologically like

lymphatic spaces. In one of the cases in which there were myriads of tiny cysts throughout the lungs, it was difficult to find epithelial cells lining the spaces. At first sight they appeared like dilated lymphatic spaces; but a careful search of many sections occasionally revealed groups of columnar cells interspersed along the flattened epithelium. In the bronchial tree there was other evidence of arrested development, as the cartilage was very scarce and plates of cartilage were found retaining their embryonic form.

In congenital cysts the epithelial lining is often thrown up into folds projecting strongly into the lumen, and it exactly resembles the form of the mucosa in the unexpanded bronchi and bronchioles of normal fetal lungs.

The epithelium that lines congenital cysts may be bronchial in type, columnar, cubical or flattened. Various types may be seen in the one cyst, and the lining epithelium may vary in form from one cyst to another.

Usually acquired cysts of the lung are not lined by bronchial epithelium. An exception to this is provided in the case of an abscess cavity, which may become secondarily lined by the spread of epithelium from communicating bronchi.

#### Smooth Muscle.

One interesting feature of congenital cysts is the frequency with which smooth muscle is found in the wall. In the walls of the cysts shown in Figure IV, muscle was constantly found in large amounts. A high-power view of part of the wall of one of these cysts is shown in Figure X, in which a large amount of muscle tissue is visible. In this particular case the cysts all possessed smooth muscle in the wall; this was found with regularity as part of what appeared to be an orderly plan. There was no cartilage in the walls of these cysts. Oudendal<sup>(12)</sup> stresses the feature of a regular arrangement of the cyst wall, lining epithelium, *membrana propria*, elastic fibres and muscle layers as indicative of a developmental origin. It is difficult to conceive of any other than a developmental origin in such a case as that illustrated in Figure IV; what acquired condition in the lung would result in multitudinous widespread cystic spaces, epithelium lined, with smooth muscle in the wall, laid down as part of an orderly plan?

In one case, that of the premature infant, cystic spaces sometimes showed cartilage in the wall, but no smooth muscle, even when this was looked for carefully and staining was carried out accordingly.

#### Cartilage.

Hyaline cartilage may be seen in the walls of congenital cysts, but this is the least constant of the tissues found normally in a bronchial wall. It may be present in a regular arrangement or may occur only in isolated patches. A few small cartilaginous nodes were found in the wall of some of the cysts in Figure III. That isolated nodes of cartilage occur in the absence of infection in the lung suggests that the cartilage is developmental in origin, and that it is not the remains of cartilage which was previously present and destroyed by infection. Isolated nodes of primitive cartilage or cartilage resembling that seen in the developing fetus occurring in the walls of uninfected cysts in adult lungs strongly favour a developmental origin. It is not safe to rely on this as evidence of arrested development in the lungs of the newborn or of young children. Isolated plates of primitive-looking cartilage may be seen in the walls of normal bronchi in infants; they are due to the fact that development of the lung continues for a number of years after birth.

#### Mucus Glands.

Mucus glands are sometimes encountered in the walls of these cysts. They were plentiful in the wall of the large cyst shown in Figure VI.

#### Alveoli.

Figures VIII and IX illustrate one interesting feature. In both illustrations the appearance is typical of large areas in these lungs as seen with the low power of the microscope. Where are the alveoli? This absence of

alveoli may be a striking feature in the affected areas. Particularly when there is no evidence of preceding inflammation or when this has been minimal, the absence of alveoli indicates, not that they have been destroyed, but rather that they have never been formed.<sup>(6)</sup> This absence of alveolar structure makes one wonder how the lungs have functioned so well as they have in life.

#### Blood Vessels.

In the architecture of normal lung, there is an orderly arrangement of blood vessels and bronchi. In this series of cases, in the affected areas of the lung this normal arrangement was lacking. In Figure IX there were numerous small blood vessels in the walls of the cysts. In this lung, and in that of the child fourteen days old, the vascularity was pronounced and in some areas the appearances resembled blood lakes. In general there was no orderly arrangement of blood vessels to cysts.

#### Connective Tissue.

Elastic fibres and fibrous tissue are commonly present in the cyst walls. Infection results in an increase in fibrous tissue, together with an increase in the lymphoid tissue. The reticulo-endothelial tissue multiplies considerably in the lung in the presence of long-standing infection.

#### Pigmentation.

It has already been stated that, macroscopically, congenital cystic lungs may be pink and fleshy in appearance and devoid of the usual carbon deposits. Microscopic examination does not always confirm this, and deposits of carbon particles may be found in the walls of the cysts or in the tissue between adjacent cysts. Koontz makes the following statement:

In patients who have reached maturity, it would often be difficult to determine whether the lesion was congenital or acquired, were it not for the total lack of pigment in the lesions, showing that the affected part of the lung had never functioned, and that therefore the pathological condition antedated birth.

Again:

These pigmented portions of lungs containing congenital defects are often sharply contrasted with adjacent portions exhibiting acquired pathological lesions of a similar nature, but which are deeply pigmented.

This is a challengeable statement, for one of the best examples of absence of pigmentation seen in this series was that of the lungs of the youth with a few bilateral cysts, most extensive bilateral bronchiectasis, a horse-shoe kidney and an undescended testis. These lungs were completely devoid of carbon pigmentation on macroscopic examination; they were pink and fleshy throughout, and certainly must have functioned through life.

#### The History of a Case of Congenital Cystic Lung.

Congenital cystic disease of the lung may be entirely symptomless, with no symptoms in life referable to the lungs, and the subject may die of some other malady after

a long life. The cystic condition is commonly found accidentally at autopsy. In the case of the oldest patient in this series, no symptoms referable to the chest had been observed, and there had been no known respiratory infection during life. Alternatively, the cystic condition may result in stillbirth, or symptoms may date from birth or soon afterwards. The mortality is high in children; there may be attacks of cyanosis and dyspnoea from birth—either the result of rupture of a cyst into the pleural cavity, or from expansion of a cyst into which air can gain entry and from which it cannot freely escape, with the production of the expansile cyst, which is frequently fatal. A cyst which has a free communication with a bronchus usually remains stationary in size, but is liable to secondary infection. Once these cysts become infected, the clinical course and behaviour will be essentially those of bronchiectasis.

Cysts which do not communicate freely with a bronchus, such as the cyst illustrated in Figure II, in which the bronchus enters and runs in the cyst wall, may be expansile. Air may be able to enter the cyst and have difficulty in escaping, with the result that the cyst may expand sufficiently to cause grave and fatal symptoms. Nearly all the cases of these balloon cysts have been reported in infants. Cysts which are filled with fluid or gelatinous material may subsequently open into bronchi and discharge their contents. Like closed epithelioid cysts elsewhere in the body, it has been stated that congenital cysts in the lung may undergo progressive enlargement. Spontaneous pneumothorax may occur at any age. When a solitary cyst becomes infected, it

behaves much as a pulmonary abscess; but it is the usual surgical experience<sup>(7)</sup> that these large, solitary, infected cysts fail over long periods of time to diminish in size despite adequate surgical drainage, collapse therapy and even thoracoplasty—a fact supported by the case illustrated in Figure VI.

In children the outstanding symptoms are dyspnoea, cough and cyanosis, accompanied by expectoration and malnutrition. In adults, cough, expectoration, dyspnoea, fever and hæmoptysis predominate.

#### Pathogenesis.

That this condition is found in the fetus, at birth, and in very young infants establishes it as congenital. This term means only that the affection is present at birth, and helps us very little indeed with regard to the aetiology. The term "developmental" is much more helpful in indicating the nature of the cystic condition. Although the opinion is held by most writers that the cysts are developmental in origin, that opinion is not unanimous.

Syphilis has been considered as a factor. In none of the patients in this series was there any evidence of syphilis, and its occurrence in some recorded cases is probably coincidental.

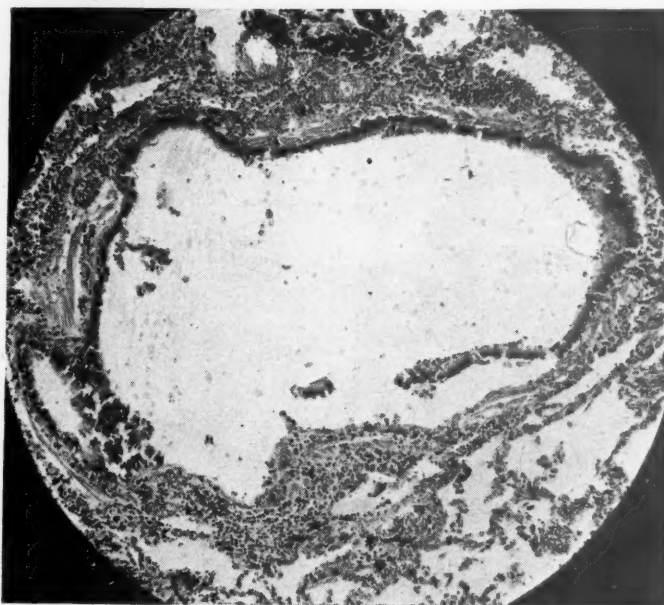


FIGURE VII.

Photomicrograph showing a cyst in the lung of a premature seven-months fetus. The epithelium, partly detached at the bottom, is bronchial in type.



That congenital cystic disease is secondary to some inflammation in the lung is not borne out by microscopic examination. In the seven-months fetus, in the child of two weeks, and in the child of fifteen months in this series, there was no microscopic evidence of any preceding inflammation. In the case of the child, aged two weeks, who did not thrive from birth, terminal acute pneumonia occurred. Although many of these lungs were heavily infected, this does not mean that the cysts were the result of inflammation, but that the infection had been superimposed upon the cystic basis. There was no evidence in the seven-months fetus that any inflammation had occurred *in utero*; the mother had experienced a normal pregnancy. If inflammation had occurred *in utero* in the next two cases in this series (infants aged two weeks and fifteen months) there was no microscopic trace of it.

Cystic disease of the lung is not a newgrowth. There is nothing to support the view that these cysts are adenomatous in origin.



FIGURE VIII.

Photomicrograph of an adult lung, showing portions of three adjacent cysts. There were vast numbers of cystic spaces lined with bronchial epithelium and with smooth muscle in the walls.

Only one case in this series lends any support to the view that the cysts are sometimes derived from lymphatic spaces. This was the case of a young man who died from cardiac failure. The cysts were for the most part lined by flattened epithelium. Nevertheless, clumps of cubical cells could be found on careful search, and there was evidence from the state of the cartilage in the bronchial tree that the true explanation was along the lines of arrested development.

The evidence brought forward in this series of cases is strongly in favour of the view that agenesis or a simple arrest of development of the bronchial tree is the important aetiological factor in this condition. Congenital cysts are derived from some part of the bronchial tree. Both the macroscopic and the microscopic findings indicate that congenital cystic disease is a malformation, the result of a disturbance of growth. In the premature infant the right lung was absent; in the fifteen-months infant again the right lung was absent—there was a rudimentary right bud at the site of the bifurcation of the trachea; in another case a horse-shoe kidney and undescended testis were

present. Lack of alveolar development was a noticeable feature when evidence of infection was absent or minimal. In another case, congenital fibrocystic disease of the pancreas was present.



FIGURE IX.

Low-power view of portions of three adjacent cysts from the lungs shown in Figure IV. The cysts are lined with cubical epithelium. Smooth muscle was regularly present in the walls of all the cysts, but no cartilage. Note absence of alveoli.

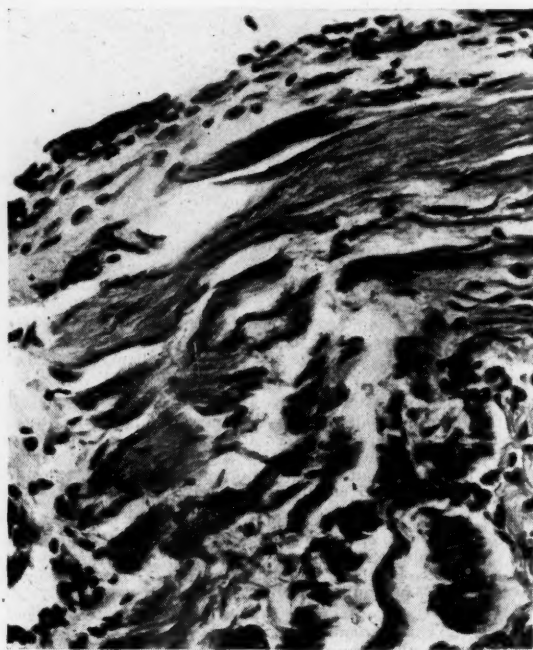


FIGURE X.

High-power view of part of the wall of one of the cysts shown in Figure IX. It is lined by cubical epithelium, and a large amount of smooth muscle is evident.

If the normal development of the bronchial tree is disturbed at any stage, the already existing elements may continue to grow without further differentiation. In this manner the various forms of congenital cystic disease may be produced. Absence of one lung is due to arrested growth of a main bronchus, which may even be absent, or present

as a rudimentary bud. If a lobe bronchus fails in differentiation, the abortive bronchus may grow out and replace the lobe by an epithelium lined cyst with bronchial elements in its wall. A subsidiary bronchus or a series of subsidiary bronchi may be affected in the same manner. That part of the lung affected will be deficient in the corresponding pulmonary lobules. The factors that operate on the lungs *in utero*, interfering with their development, are unknown, but there are many possibilities.

It is conceivable, then, that the distribution of the cysts in the lung depends upon the part or parts of the developing bronchial tree that are affected, and that the various types of the malformation depend for their features upon arrest of development and upon the stage of growth reached before further differentiation fails.

#### Acknowledgements.

I wish to record my indebtedness to Professor P. MacCallum for his assistance in this work, which was carried out in his department. I should also like to thank Dr. R. J. Riddell, of the Women's Hospital, Melbourne, for an opportunity of studying the premature seven-months fetus. The subject of congenital cystic disease of the lung and fibrocystic disease of the pancreas was a specimen obtained by Dr. A. Pound. I was also helped in the collection of this material by the late Dr. R. J. Wright-Smith. The editors of *The Royal Melbourne Hospital Clinical Reports* gave me permission to reproduce three illustrations from a previous contribution.

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### THE ROYAL PRINCE ALFRED HOSPITAL CANCER OF THE UTERUS FOLLOW-UP.

By HERBERT H. SCHLINK, CLEMENT L. CHAPMAN and  
FREDERICK N. CHENHALL,  
From the Royal Prince Alfred Hospital, Sydney.

THE Commonwealth of Australia made a plentiful supply of radium available to the hospitals of Australia in 1928-1929, and the gynaecological department of the Royal Prince Alfred Hospital, Sydney, has since the beginning of 1930 made free use of it in the treatment of cancer of the cervix uteri. We adopted the combined treatment—that is, radium is applied to all patients presenting themselves for treatment, and those considered operable are, after five to six weeks, submitted to the radical Wertheim hysterectomy, which clears out the draining lymph gland areas.

About 50% of the patients treated have been found operable, and of those operated upon about 25% had secondary involvement of the lymph nodes—a fact which justifies our claim that 70% of patients presenting themselves for treatment under existing conditions already have gland involvement. As radium or deep X-ray therapy has no effect on squamous or adenocarcinomatous deposits in lymph glands, the reason for our superior results from added surgery is obvious.

The microscopic examination of the removed radium-treated uteri has greatly added to our knowledge of

radium-sensitive and radium-insensitive growths and has led us to decide upon a routine dose of 7000 milligramme-hours. A tube of radium of thirty milligrammes with one millimetre of platinum screenage is applied to the full length of the uterine cavity, and two corks with twenty milligramme tubes of radium screened by two millimetres of platinum are applied to the lateral fornices of the vault. The heavier screenage of the vault tubes was decided upon to prevent burning of the vaginal mucosa. All tubes are left *in situ* for 100 hours and then removed.

TABLE I.

*The Royal Prince Alfred Hospital Five- and Ten-Year Cure Rate in Cancer of the Cervix Uteri, 1930 to 1941, Compiled December 31, 1946.*

Condition of Patients.	Five-Year Cure.	Ten-Year Cure.
Patients examined with a view to treatment	407	228
Patients treated: all diagnoses microscopically proved	391	215
Alive without recurrence after five years	128	48
Alive with recurrence after five years	3	1
Died of cancer	245	150
Died of intercurrent disease	9	6
Lost or not followed up	6	2
Five- and ten-year cure rate amongst all patients examined	31.2%	21.0%
Five- and ten-year survival rate amongst all patients examined	32.1%	21.5%
Five- and ten-year cure rate amongst all patients treated	32.7%	22.3%
Five- and ten-year survival rate amongst all patients treated	33.7%	22.7%

From our study of the reports of the various world clinics, we estimate that we are getting 5% better results in our five and ten year cures than clinics which use radiotherapy alone or straight-out surgery. This year we publish our figures for 1930 to 1941. The books were closed on December 31, 1946.

Our operative mortality is lower than any recorded figures we have seen; there were 311 radical Wertheim hysterectomies with 18 deaths (5.7%) spread over all the cooperating surgeons at the King George V Memorial Hospital.

TABLE II.

*Survival Rate After Exclusion of Group IV and Deaths from Intercurrent Disease (All "Lost" Patients Assumed to be Dead), Compiled December 31, 1946.*

Treatment.	Group IV Excluded.		Both Group IV and Intercurrent Disease Deaths Excluded.	
	Five Years.	Ten Years.	Five Years.	Ten Years.
Radium and surgery	56%	42%	60%	57%
Radium alone	18%	8%	18%	9%
Both methods	40%	27%	43%	31%

As controversy has in the past centred around the correct method of cervical cancer treatment, and as world opinion is almost unanimous about the surgical treatment of the uterine corpus being the treatment of election, we have concentrated our attention on the cervix to the statistical neglect of the corpus. However, measures have been taken to follow up all patients with cancer of the corpus uteri from January 1, 1930, so as to present the facts concerning cancer of the whole organ.

In this contribution to the subject, we give our corpus figures for the follow-up to date; but insufficient time has been given for the Registrar-General, the police and our secretarial department to make the figures complete. When all patients have been traced or proved dead, the five and ten year cure rates of corpus cancer will, we believe, be much higher.

When world statistics are studied, it would appear that some cancer clinics do not accurately separate these two

TABLE III.  
Carcinoma of Uterine Cervix, 1930 to 1941.

Carcinoma of Cervix Cervicæ, 1900 to 1922.

Technique.	Stage I.		Stage II.		Stage III.		Stage IV.		Total.		Per-centage.	
	Number.	Alive.	Number.	Alive.	Number.	Alive.	Number.	Alive.	Number.	Alive.		
Five-Year Cure Rate.												
Radium and surgery .. .. .	32	24	80	46	78	37	—	—	190	107	56.0	
Radium .. .. .	2	2	21	7	112	15	59	—	194	24	12.3	
Nil, or incomplete treatment .. .. .	—	—	—	—	6	—	17	—	23	—	—	
Total .. .. .	34	26	101	53	196	52	76	—	407	131	32.2	
Ten-Year Cure Rate.												
Radium and surgery .. .. .	15	10	44	16	41	16	—	—	100	42	42.0	
Radium .. .. .	2	—	7	2	66	4	40	—	115	6	5.2	
Nil, or incomplete treatment .. .. .	—	—	—	—	2	—	11	—	13	—	—	
Total .. .. .	17	10	51	18	109	20	51	—	228	48	21.0	

types of uterine cancer which react so differently to radiotherapy and surgery. All surgeons know how amenable uterine body cancer is to surgery alone, and if these malignant body cancers are mistakenly or deliberately classified as cervical cancers, the figures for the results of the various types of treatment will be out of all proportion to the scientific truth.

Our own practice in the differential diagnosis in cases in which there is a doubt as to whether the cancer originated in the cervix or in the corpus is to classify the cancer as originating in the corpus.

TABLE IV.  
Carcinoma of Uterine Body, 1930-1941.

Technique.	Number of Patients.	Patients Alive.
Five-Year Cure Rate.		
Radium with surgery, and surgery alone	60	40
Radium .. .. .	16	3
Nil, or incomplete treatment .. .. .	2	—
Total .. .. .	78	43
Ten-Year Cure Rate.		
Radium with surgery, and surgery alone	34	11
Radium .. .. .	8	—
Nil, or incomplete treatment .. .. .	2	—
Total .. .. .	44	11

Since 1930 we have passed through our unit 822 patients with cancer of the womb, 683 patients with cancer of the cervix, and 139 patients with cancer of the corpus, with results as shown in the attached tables. Table I gives the overall facts of five and ten year cures for all forms of treatment administered by the department. Table II demonstrates the better results that would be obtained if patients presented themselves in the early stages of the disease. We have great hopes that the Papanicolaou test, when generally practised, will bring this about. Table III shows the detail of Table I. Table IV gives the results of treatment of cancer of the corpus, from 1930 to 1941.

#### Acknowledgements and Recommendations.

Follow-ups of any kind are a great financial burden on a hospital and demand a great toll of energy on the part of many people. We therefore wish to thank the directors for their liberality, the Police Department and the

Registrar-General for their help in untraced and lost cases, our pathologists, Dr. Geoffrey Davies and Dr. Mary Heseltine, and their assistants, Miss Cunningham and our personal secretaries, and the nursing and operating staffs. They have all helped to secure an important piece of factual work on uterine cancer published in Australia, notwithstanding all the present loose talk of cancer prevention and research, and the unwarranted interest in lay "quack" treatment. We feel that the time is long overdue for some financial support to be forthcoming, either from the Government which has funds set aside to fight cancer, or from the University of Sydney, which still holds money subscribed for the purpose, to carry on what is the essence of all research—the collection of facts. Our honorary duties to the hospital do not demand any such effort. All members of the staff are, however, willing to continue and desirous of continuing to contribute their energy and interest to the cause of public health, but are urgently in need of assistance. Up to the present, our department has received no help whatever from any government or fund, with the exception of the generous gift of radium from the Commonwealth Government. Clinical research is every bit as important as academic laboratory research in the solution and cure of this treacherous and devastating malady.

## Reviews.

### ***PATHOLOGY OF NUTRITIONAL DISEASE.***

RICHARD TOLLIS's book on "The Pathology of Nutritional Disease" fills a gap in the literature of the subject.<sup>1</sup> Although much data on the changes that occur in mammals in specific deficiency states are to be found scattered through general text-books on nutrition, this volume represents an attempt to collect and collate available information at the time of writing.

The first and most lasting impression is the limited amount of space devoted to the pathological changes found in man. The author was conscious of this, for he comments upon it in the preface. The explanation is, of course, that knowledge of the human species is meagre; many of the deficiency states have been studied experimentally in animals, and have not been observed to occur spontaneously in man, nor have they been induced experimentally.

The subject matter is grouped under four major and two minor headings. The major subjects cover the pathology of deficiencies due to the essential mineral elements, the

<sup>1</sup>"The Pathology of Nutritional Disease: Physiological and Morphological Changes which Result from Deficiencies of the Essential Elements, Amino Acids, Vitamins and Fatty Acids", by Richard H. Tollis, Junior, M.D.; 1948. Oxford: Blackwell Scientific Publications, Limited. 10" x 6½", pp. 306, with many illustrations. Price: 35s.



essential amino acids, the vitamins and the so-called essential fatty acids. The other chapters give an introduction to the subject, a summary of the pathology of specific tissues.

Each nutrient is treated in a standardized pattern; a brief introduction gives the highlights of its history, a brief review of its biochemical relationships and then the pathological effects of the single deficiency of the nutrient first in laboratory animals and then, if applicable, in man.

The author has reviewed the extensive literature on this subject, but has also drawn heavily upon his own experiences as a pathologist. Thus reference is made to the incidence of several deficiency states observed in children who have come to autopsy as a result of other diseases.

Of the fourteen elements discussed in the first section three have special interest for the student of human disease, namely, iron, iodine and fluorine (calcium is considered in detail with vitamin D). Iron is treated briefly and more space could have been devoted to the factors controlling the absorption and utilization of this element. Knowledge of iodine metabolism has been advanced appreciably in the last year or so by the use of isotopes and thioracil in laboratory animals; the lack of this data has handicapped the author.

Changes due to vitamin deficiencies are set out in considerable detail. This is the best section of the book and should have the greatest appeal to the physician. Emphasis has been placed upon the fact that it is unlikely that uncomplicated thiamine, riboflavin and niacin deficiencies ever occur in man. With this safeguard a full description is then given of the pathology of beriberi, ariboflavinosis and pellagra, conditions frequently attributed to the deficiency of thiamine, riboflavin and niacin respectively. Mellanby's recent work on the pathology of bone in vitamin A deficiency provides an explanation for many of the nervous signs that the author finds difficult to explain.

The section on the amino acids is largely of academic interest, for it is unlikely that specific deficiency of isolated amino acids is likely to occur naturally in man. The term "essential fatty acids" has until recently been limited to animals, but the possibility that these nutrients may be associated with some of the allergic states is noted.

This book is well illustrated with photographs of animals with deficiency diseases and of isolated signs in human subjects and with excellent photomicrographs of histological changes. The effects in laboratory animals of the deficiency of specific nutrients occupy a large part of the book, but this should not reduce its interest for the medical man. Observations made on laboratory animals enable the clarification of signs seen in the human and should form the basis of progress in human studies. This publication should appeal to pathologists, the students of nutrition and physicians, especially those interested in the health and nutrition of children.

#### MINOR SURGERY.

The appearance of the sixth edition of "Minor Surgery" by Frederick Christopher proves its popularity and worth.

Like its counterpart, "Textbook of Surgery", by the same author, this book is to be found on many Australian bookshelves. It is probably the most comprehensive book on minor surgery available today and nothing but praise can be showered on the volume.

It is thoroughly up to date and the latest antibiotics, including tyrothricin and their applications and limitations, are discussed. Recent views on thrombophlebitis and phlebotrombosis are expounded; also included are subjects such as the use of oxidized cellulose, the use of procaine in serum sickness, refrigeration anaesthesia, hypoproteinaemia, tularaemia and peritoneoscopy. In this volume one finds a consideration of the pathogenesis, diagnosis and treatment of those conditions which comprise the large majority of surgical affections. One reads that all sebaceous cysts should be removed, as 3.4% become the site of malignant tumour. The wholesale use of gonadotropic hormones is discouraged in cryptorchidism. These hormones should never be used in cases of unilateral maldescent of the testes, but only when both testes are undescended and there is subnormal genital development.

In the chapter on minor surgical procedure no mention is made of the technique of cisternal puncture. The all-

"Minor Surgery", by Frederick Christopher, M.D., B.S., F.A.C.S.; Sixth Edition; 1948. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9 1/2" x 6 1/2", pp. 1068, with many illustrations. Price: 34s.

important subject of pre-operative and post-operative care is fully and intelligently discussed.

Extraordinary care has been exercised in reviewing every branch of the subjects, as evidenced by the formidable list of references at the end of each chapter. No adverse criticism can be directed against this book, which should be available to every practising clinician.

#### INFANT WELFARE.

"THE MOTHERCRAFT MANUAL" by Mabel Liddiard<sup>1</sup> has reached its eleventh edition in twenty-five years and therefore may be considered to meet a definite demand. In general, the book follows the teaching of the Truby King school, even to the extent of urging the use of the Truby King proprietary preparations. It contains a mass of information covering all aspects of infant welfare from ante-natal days to the toddling stage. In particular, bathing, routine changing and feeding are described with meticulous attention to detail. However, much of the information regarding food is applicable to English conditions where government issues are available to supplement the diet of mother and child. Unfortunately some of the advice given is at variance with modern ideas. The instruction to pregnant women to avoid overtaxing their kidneys with too much protein finds no support in the present-day advocacy of a high protein diet during pregnancy; the advice on dental attention during pregnancy errs on the side of over-timidity; while the section on preparation of the breasts takes no account of recent work on this subject. And, with the present problems of domestic assistance and accommodation, as well as upon purely medical grounds, it is difficult to understand the author's preference for confinements conducted in the home. The information presented is not applicable to Australian conditions and is behind that in current Australian works on the subject.

#### EMERGENCY SURGERY.

OWING to binding difficulties the sixth edition of Hamilton Bailey's "Emergency Surgery" is being produced in five parts.<sup>2</sup> Part I is the subject of this review and once again it is a privilege to discuss this now well-established surgical classic.

The first four chapters are devoted to methods of fluid replacement, stress being laid on correct fluid balance. Brief mention only is made of the parenteral administration of amino acid solutions, due to the then-existing difficulty of their procurement in Great Britain. More about this will certainly be written in the next edition. In their absence Ishister has recently shown that the level of plasma proteins can be efficiently and quickly raised by plasma infusion.

In discussing direct compatibility tests using stored blood (page 32, last paragraph), it is stated that a sample of the stored blood may be taken from the flask with a sterile glass rod after removal of the screw top. To obviate this possible means of contamination, it is better to place a sample of the blood in a little sealed tube at the time of taking and fasten it with wire to the bottle as is done by the Red Cross Blood Bank in Sydney.

In the chapter on anaesthesia, Hamilton Bailey rightly decries inhalation anaesthesia. More might be said, however, on the combination of "Pentothal" and the curare preparations now so much in vogue for abdominal anaesthesia. Few anaesthetists will agree that "on no account should nembutal or other barbiturates be ordered when pentothal is used". Indeed it is a very common practice and the "Nembutal" acts as a good indicator to show the tolerance of the patient for the barbiturates. A marked response to a small dose of "Nembutal" will make one careful with the "Pentothal".

It would be fitting in this chapter to stress the importance of an empty stomach in all patients about to undergo an emergency operation under any anaesthetic agent, even local anaesthesia. The passage of a Ryle's tube with with-

<sup>1</sup>"The Mothercraft Manual or the Expectant and Nursing Mother and Baby's First Two Years", by Mabel Liddiard, Introduction by Dorothy M. Taylor, M.D., D.P.H.; Eleventh Edition; 1948. London: J. and A. Churchill, Limited. 7 1/2" x 5", pp. 190, with many illustrations. Price: 5s.

<sup>2</sup>"Emergency Surgery", by Hamilton Bailey, F.R.C.S. (England), F.A.C.S., F.L.C.S., F.R.S.E.; Part I, Sixth Edition; 1948. Bristol: John Wright and Sons, Limited. London: Simpkin Marshall (1941). Limited. 10" x 6", pp. 188, with many illustrations, some of them coloured. Price: 21s.

drawal of the stomach contents will prevent many tragedies due to the inhalation of food down the trachea. When "Pentothal" is used vomitus may cause a frightening laryngeal spasm. Should laryngeal spasm occur due to "Pentothal", curare will overcome it.

The chapter on impending death under anaesthesia is very instructive indeed. The "Emergency Anaesthetic Outfit" is an excellent idea. It could even be extended to include sterilized instruments to make the incision for cardiac massage. Collapse under anaesthesia often occurs during such operations as tonsillectomies, and valuable time may be lost obtaining sterilized (or even unsterilized) instruments for this purpose.

The principles of the treatment of peritonitis are fully discussed. Now that penicillin is freely available it will come much higher up on the list of the bulwarks of conservative treatment given on page 110. The use of streptomycin in tuberculous peritonitis will doubtless be included in the next edition. The efficacy of cortin and of anti-gas-gangrene serum is very problematical. Few surgeons now use sulphanilamide powder as freely as Hamilton Bailey does in the peritoneal cavity or the wound, powdered penicillin being used in its stead. The placing of powdered sulphanilamide intraperitoneally may be followed by jaundice and later adhesions.

The surgery of acute appendicitis is dealt with thoroughly. It is rarely necessary to evert the caecum as shown in Figure 207. Warning might be given of the presence of the branch from the posterior caecal artery forming the "angular anastomosis" at the base of the appendix, as it can cause troublesome bleeding if it is not ligated. Fewer and fewer surgeons use carbolic acid to touch the appendiceal stump and many do not insert the purse-string suture in the caecum. It is pleasing to note that the "lump" in the right iliac fossa associated with the early inflamed appendix is termed a "phlegmon", the term abscess being reserved for the later stage when pus is actually present.

On page 144 is given a graphic case history of a patient suffering from a pelvic abscess which every young surgeon should read and re-read, so vivid is its portrayal.

Conditions simulating acute appendicitis are described in detail. One feels, however, that the conservative treatment of the acute phase of Crohn's disease with a careful follow-up of the patient is important, as many of these acute conditions do subside without the necessity of a bowel resection.

It is to be hoped that in the later sections a chapter on post-operative care will be included with special emphasis on the value of bowel rest and the dangers of aperients and enemata as have been continually stressed by Victor Kinsella, of Sydney.

There is no need to recommend this book to those whose fortune it is to be responsible for the care of patients requiring emergency surgery; its fame was established with the first edition. The artists deserve high praise for the illustrations and the publishers for the book itself.

#### EXERCISES FOR WOMEN.

In "Restoration Exercises for Women", by Ettie Rout (Mrs. Hornibrook), a very excellent attempt has been made by the author to help women regain and retain their health by means of common-sense exercises.<sup>1</sup>

The book is lavishly illustrated, which, particularly where exercises are concerned, is most helpful. The first chapter deals with posture to counteract constipation and also to ensure easy and safe evacuation of the contents of the lower bowel. The book would be of value if for no other reason than for the inclusion of this one section. A great amount of space is given to special exercises for strengthening the abdominal wall, particularly after pregnancy, and also for aging women whose muscles tend to sag; a great deal can be done by corrective measures to stop the tendency to "spread out and sag down". If the author can help women to prevent this, she will be a boon to society. Then again, there are many excellent exercises for foot troubles, incorrect walking *et cetera*.

We recommend this as a very excellent little book and one which every husband should buy for his wife and every doctor should recommend to his patient, both for her physical well-being and for her morale.

<sup>1</sup> "Restoration Exercises for Women: New and Revised Edition Embodying 'Stand Up and Slim Down'", by Ettie Rout (Mrs. Ettie Hornibrook), prefaces by Sir Arthur Keith, F.R.S., M.D., F.R.C.S., LL.D., and the late Dr. A. C. Haddon, M.A., Sc.D., F.R.S.; Ninth Edition; 1948. London: William Heinemann (Medical Books), Limited. 8½" x 5½", pp. 96, with many illustrations. Price: 7s. 6d.

#### Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"Aids to Ophthalmology", by P. McG. Moffatt, M.D. (Lond.), M.R.C.P., F.R.C.S. (Eng.), D.O.M.S.; Tenth Edition; 1948. London: Baillière, Tindall and Cox. 6½" x 4", pp. 272, with illustrations. Price: 6s. 6d.

A condensed book on ophthalmology brought up to date.

"The Case of Augustus D'Esté", by Douglas Firth, M.A., M.D. (Cantab.), F.R.C.P. (London); 1948. Cambridge: University Press. 7½" x 4½", pp. 70. Price: 6s.

The earliest clinical account of disseminated sclerosis, described by its victim, grandson of George III.

"A Way to Natural Childbirth: A Manual for Physiotherapists and Parents-to-be", by Helen Heardman; 1948. Edinburgh: E. and S. Livingstone, Limited. 7" x 4½", pp. 134, with illustrations. Price: 7s. 6d.

Describes how the expectant mother may be trained in the practice of relaxation in labour.

"Bacterial and Virus Diseases: Antisera, Toxoids, Vaccines and Tuberculin in Prophylaxis and Treatment", by H. J. Parish, M.D., F.R.C.P.E., D.P.H.; 1948. Edinburgh: E. and S. Livingstone, Limited. 8" x 4½", pp. 167, with illustrations. Price: 7s. 6d.

The essential principles of immunology and their practical application summarized for busy practitioners and senior students.

"Manual of Public Health: Hygiene", by J. R. Currie, M.A. (Oxon.), M.D., LL.D. (Glas.), D.P.H. (Bir.), F.R.C.P. (Edin.), and A. G. Mearns, M.D., B.Sc. (Public Health), D.P.H. (Glas.), F.R.S. (Edin.); Third Edition; 1948. Edinburgh: E. and S. Livingstone, Limited. 8½" x 5½", pp. 746, with illustrations. Price: 35s.

A much enlarged edition of a book intended for the use of students of medicine.

"A History of the Heart and the Circulation", by Frederick A. Willius, M.D., M.S. in Med., and Thomas J. Dry, M.A., M.B., Ch.B., M.S. in Med.; 1948. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9" x 6", pp. 475, with illustrations. Price: 55s.

An account of the historical development of knowledge relating to the heart and circulation by two cardiologists from the Mayo Foundation.

"Treatment of Heart Disease", by William A. Brams, M.S., M.D., Ph.D.; 1948. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9" x 6", pp. 211, with few illustrations. Price: 24s. 6d.

A guide in the treatment of heart disease for the general practitioner and the medical student.

"The Clinical Apprentice: A Guide for Students of Medicine", by John M. Naish, M.D. (Cantab.), M.R.C.P., and John Apley, M.D. (Lond.), M.R.C.P., with a foreword by Professor J. A. Ryle; 1948. Bristol: John Wright and Sons, Limited. 7½" x 4½", pp. 214, with illustrations. Price: 15s.

A guide for medical students in the clinical examination of patients.

"Aids to Biology", by R. G. Nelli, M.A.; Second Edition; 1948. London: Baillière, Tindall and Cox. 6½" x 4", pp. 289, with few illustrations. Price: 6s.

An elementary book on the principles of biology and the fundamentals of physiology.

"Medullary Nailing of Küntscher", by Lorenz Böhrer, M.D.; first English edition, translated from the eleventh German edition by Hans Tretter, M.D.; 1948. Baltimore: The Williams and Wilkins Company. Sydney: Angus and Robertson, Limited. 10" x 6½", pp. 400, with illustrations. Price: 52s. 6d.

A full account and critical evaluation of the use of Küntscher's medullary nail.

"Twentieth Century Speech and Voice Correction", edited by Emil Froeschels, M.D.; 1948. New York: Philosophical Library. 8½" x 5", pp. 336, with illustrations. Price: not stated.

Intended to offer to persons scientifically and/or practically interested in speech and voice correction the latest developments in this field.

"Human Histology: A Guide for Medical Students", by E. R. A. Cooper, M.D., with a foreword by F. Wood Jones, F.R.S., F.R.C.S.; Second Edition; 1948. London: H. K. Lewis and Company, Limited. 8½" x 5½", pp. 446, with illustrations, some coloured. Price: 27s. 6d.

A guide to histology for medical students arranged in accordance with the course given at the University of Manchester.

# The Medical Journal of Australia

SATURDAY, SEPTEMBER 18, 1948.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

## COMPLETE PHYSICAL FITNESS.

MEDICAL OFFICERS who spent long weary days in the early war years examining the men who passed through the recruiting organization, that was often quite aptly described as a sausage machine, must have paused at times to wonder just how much bread and how much meat really made up the sausages that looked well enough on the outside. This extension of the sausage machine metaphor to the men involved is not intended to belittle them in any way; very often the system did just that, and if the extended metaphor reflects adversely at all it is on the system, not on the men. How far the system can be improved is another matter. Evidence was soon forthcoming that the selection system was not uniformly successful. For example, in a report received from the Director-General of Army Medical Services and published in this journal on January 25, 1941, medical officers of the Hospital Ship *Manunda* listed and discussed conditions found in their patients which made the men militarily unfit and of many of which at least some evidence should have been present at the time of enlistment. Comment was made in these columns at the time and it was pointed out that absolute standards of fitness were necessary for men entering the forces; fitness more accurately referred to the individual's capacity to carry out his allotted task, but under conditions of war service every man needed to be ready for all eventualities—he was either fit or unfit. Perhaps indeed the standard for the man who is to engage in the corroding business of war should be even more exacting than such a report would suggest. Lord Moran in his book "The Anatomy of Courage" (which was based on his experience as a battalion medical officer in France during the 1914-1918 war, written early in the recent war and published in 1945) makes many thoughtful observations on the subject. He sets out in his book "to find how courage is born and how it is sustained in an army of free people". After discussing in the first two parts of his book "The Discovery of Fear" and "How Courage is Spent" he devotes the third part to "The Care and Management of Fear", his first consideration being the selection of men for an army, the subject relevant to our

present discussion. Those whose character or temperament makes them incapable of fighting, he says, must be weeded out; if this is not done by the recruiting board or during training, war will do it "with a quite ruthless precision of its own". He suggests, while admitting that he may be wrong, that the armies of long ago were recruited from men who did not feel fear, phlegmatic yokels whose imaginations played no tricks; the principle of selection of such men depended on physical appraisal.

But in the modern world war has become the business of millions, willing and unwilling; the tape measure is not enough. Courage is no longer the product of a vacant mind, it is the expression on the battlefield of character.

Selection on such a basis is unquestionably difficult, but it must be aimed at. Lord Moran considers that at least a recruiting board should be able to detect signs and symptoms of nervous instability and to determine the "simple" by an elimination test; a conduct sheet would be a great help, but naturally there is no such document for the majority of recruits. Many psychological tests have been devised, especially aptitude tests; their value is sometimes debatable, but the idea must be encouraged. Objective standards are essential, for there are few people with the capacity of the great industrialist who once said to Moran: "I know when a man enters the door if he is my man." Another interesting selective factor is what Moran calls "natural selection", the segregation into the army of men who do not fit into the structure of society, and he quotes Bacon's words: "All warlike people are a little idle, and love danger better than travail." At the same time he indicts the society which can find no place for those who have stood the test of war. He is also critical of peace-time standards which make it possible to claim that a man's fitness in war cannot be estimated in peace, for "a man of character in peace becomes a man of courage in war".

If we once believe that the capacity to get on in life is not everything, we shall be in a fair way to employ in peace tests of character as searching as those which the trenches supplied in war.

However, there are even wider issues than these, for ultimately our plans must be for peace and not for war. What standards of selection have we for fitness in peacetime? Much comment has been made when, after examination of a comprehensive selection of the community as for compulsory training or conscription, the proportions are made known of those in less than the highest categories of physical fitness. While the importance of such assessments should not be underrated, it is not always valid to apply them to the civil community. The absence of physical defect is not enough in the armed forces, though it is important; but its importance may be only relative for the civilian. As was pointed out in a recent American report, physical fitness describes the functional capacity of the individual for a task; it has no real meaning unless the task or job is specified for which fitness is to be judged. As used in this report,<sup>1</sup> which was compiled by a subcommittee of the Baruch Committee on Physical Medicine consisting of R. C. Darling, L. W. Elchna, C. W. Heath and H. G. Wolff in consultation with many experts in particular fields, the term physical fitness has a broader meaning than that frequently used and includes the variety

<sup>1</sup> The Journal of the American Medical Association, March 13, 1948.



of factors which affect human performance. This serves to throw into relief the limited value *per se* of what is usually styled physical fitness. The only final test of fitness, according to the report, seems to be the ability to perform the task desired without undue fatigue or exhaustion, and the qualities making this possible are those of the total personality.

Physical fitness for a task depends on the physical equipment and physiologic competence of the subject for the stress which the task imposes, together with the complex psychologic factors grouped under the term "motivation". The physical and psychologic factors cannot be fully dissociated even in test procedures.

It is emphasized that the appraisal of physical fitness depends on dynamic or functional factors rather than static or anatomical factors, and it is important that the functional capacity of the subject be evaluated, whenever possible, by appropriate tests of working capacity and vasomotor response. It is equally important that the psychological evaluation should include an appraisal of the total personality. Sometimes the assistance of a psychiatrist may be needed, but as a rule it is quite reasonable and indeed preferable that the subject's own doctor should make the assessment, the best judgement most often coming from frequent contact when the subject is seen "as he is" in his work and under the stresses of his daily life. Other factors mentioned by the report include sex, age, and the presence of a specific physical defect which may have ceased to be significant to the individual.

A term which recurs throughout the report is "motivation", "the goal which a man seeks consciously or unconsciously by his efforts, his 'will to do' and 'will to succeed'". This must be a fundamental factor in determining fitness for any task, for it links up the fitness of the man for the task with the fitness of the task for the man. In the latter our complex modern civilization has offended deeply. It is tragically obvious that for very many a sense of vocation does not exist. It would be strange if it did exist for a man whose daily task is monotonous and practically meaningless. D. R. Davies tells us that observation of the workers in the Ford factories at Detroit was a major factor in making Reinhold Niebuhr a Christian revolutionary and one of the great prophets of modern America, for he was roused by the disastrous effects of this vast mechanism which dehumanized and depersonalized the worker at the same time. Such work very quickly destroys the worker's initial physical fitness and a vicious circle is set up. A great deal of the unrest and sense of frustration which pervade not only the industrial world but most fields of activity today must be due to neglect of these same factors—the interaction of the fitness of the individual and the fitness of the task, on which "motivation" and a sense of vocation depend. Dorothy L. Sayers in her provocative little essay "Why Work?" asserts that

work is not, primarily, a thing one does to live, but the thing one lives to do. It is, or it should be, the full expression of the worker's faculties, the thing in which he finds spiritual, mental, and bodily satisfaction, and the medium in which he offers himself to God.

These may sound very high words, but a practical understanding and experience of what they mean would go far to bring many now outside into the ranks of the truly physically fit.

## Current Comment.

### "SULPHETRONE."

In 1937 G. A. H. Buttle *et alii*<sup>1</sup> reported the use of diaminodiphenylsulphone which was found to be active in curing streptococcal infections of mice in doses of about one one-hundredth of those required with sulphanilamide; it was, however, 25 times as toxic. That was in the early days of chemotherapy (the article appearing next to that by Buttle *et alii* described the clinical results from the treatment of erysipelas by "Prontosil") and the sulphonamide drugs soon dominated the field. Search was, however, continued for a less toxic derivative of diaminodiphenylsulphone, and tetrasodium, 4:4-bis( $\gamma$ -phenylpropylamino) - diphenylsulphone —  $\text{a}:\gamma:\text{a}':\gamma'$  - tetrasulphonate ("Sulphetrone"), attracted some attention by reason of its relative freedom from toxicity and its potent antituberculosis activity. Not much has been heard of its use till recently, but its clinical trial has been going on. In 1947 D. G. Madigan *et alii*<sup>2</sup> described its use in association with streptomycin in the treatment of tuberculosis. The series was small and the results were equivocal, but Madigan and his colleagues considered that those patients who received "Sulphetrone" also appeared to improve more than those treated with streptomycin alone. Now a further group of reports has come to hand. George Brownlee<sup>3</sup> has described the chemical and pharmacological properties of "Sulphetrone" in some detail. No acute toxic effects from its use have been observed in man. A chronic hæmotoxic effect is seen in rabbits and in man with the production of anemia, but this can be controlled. "Sulphetrone" penetrates all tissues, except brain, very rapidly; it passes into the cerebro-spinal fluid more slowly than do sulphonamides. It has been found to be bacteriostatic, having a suppressive effect on progressive experimental tuberculosis in guinea-pigs; in common with other sulphones, it is incapable of eliminating the infective organism from animal tissues. It has also been shown that "Sulphetrone" is more efficient than "Promin" in protecting the laboratory animal against experimental tuberculosis and that it is synergic with streptomycin.

The first of the recent reports on the clinical trial of "Sulphetrone" is made by T. Anderson and S. J. Strachan, of Glasgow.<sup>4</sup> They have treated 100 patients suffering from tuberculous conditions of varying type and severity. "Sulphetrone" even in large doses exerted no beneficial effect on the course of tuberculous meningitis, miliary disease or bronchopneumonia. Of a group of fifteen patients with advanced bilateral pulmonary involvement, whose prognosis was bad and who were unlikely to derive benefit from any form of treatment, only one responded to "Sulphetrone", but the result in that instance has been satisfactory. Of 36 patients with moderately advanced pulmonary disease 23 showed evidence of improvement after a period of "Sulphetrone" therapy. Definite improvement was noted in 15 of 19 children (all under the age of fifteen years) with a variety of forms of tuberculosis. Six of ten with pleurisy with effusion derived definite benefit and two were slightly improved. A small number of patients with genito-urinary and skin tuberculosis were treated; they were too few for the results of treatment to be significant, but the investigators were impressed with the rapidity and completeness of the cure of cutaneous tuberculosis. Among toxic effects anemia and cyanosis occurred in all cases, headache, nausea and vomiting were common and ten patients developed a sensitization rash. Anderson and Strachan are of the opinion, however, that "Sulphetrone", if given in a satisfactory way, which they describe, is not unduly dangerous, but merely demands reasonable caution. In discussing indications for "Sulphetrone" therapy, they refer to the patient in whom the infection is controlled, but who is left with lungs so seriously damaged with old disease that healing is beyond

<sup>1</sup> *The Lancet*, June 5, 1937.

<sup>2</sup> *Ibidem*, December 20, 1947.

<sup>3</sup> *Ibidem*, July 24, 1948.

<sup>4</sup> *Ibidem*, July 24, 1948.

his capacity. If lung involvement is bilateral, surgical collapse methods may not be practicable, and in such cases they feel that "Sulphetrone" therapy may sometimes be justified with the limited objective of arresting disease in one lung (where it is recent and infiltrative) to permit surgical attack on the more extensively diseased opposite lung; this was achieved in four cases in their series. The type of patient who seems to them most likely to benefit is the one with an early infiltrative lesion; this is based on their general experience, though they have had unexplained failures in certain cases. Their general attitude to the drug is guarded but favourable. D. G. Madigan<sup>1</sup> describes the use of "Sulphetrone" therapy in seventy cases of tuberculosis affecting different organs. In general no beneficial effect was detected in acute infections, such as acute miliary tuberculosis and tuberculous meningitis, but a patient with chronic miliary tuberculosis recovered. On the other hand, improvement was observed in chronic lesions. In 12 out of 17 cases of acute pulmonary fibro-caseous disease, and in 13 out of 22 chronic cases, improvement was noted. Benefit was derived in all of four cases of primary pulmonary tuberculosis and in six out of eight cases of strictly exudative lesions. In the chronic hæmatogenous group all of four patients improved, and in the productive pulmonary infiltrative group three out of four patients improved. Madigan considers that in general all exudative phases of infiltrative disease were halted and reversed by the administration of "Sulphetrone". He emphasizes the need for long-continued courses and for routine laboratory control and sums up with the opinion that "Sulphetrone" is "useful as an adjuvant with definite objectives in view". The same general conclusion was reached by M. G. Clay and A. C. Clay, of Aberdeen,<sup>2</sup> from the treatment of 44 patients. Their results briefly were that improvement was noted in 22 cases; nine patients improved considerably, seven moderately and six slightly, the improvement not being dramatic. Toxic side-effects were observed in six patients; these effects disappeared on withdrawal of the drug. The necessity is expressed for facilities for estimating blood "Sulphetrone" levels and for carrying out blood counts. The final conclusion of the Clays is that at best "Sulphetrone" can be regarded as only an adjuvant and not in any way as a specific for tuberculosis. This is probably the essence of the opinions of all the investigators, though they are not all quite so cautious. No mention has been made here of the details of other coincidental treatment which is described in the several reports, but all the investigators have taken this into consideration. The unpredictable course of tuberculous infections and the impossibility of arranging satisfactory controls are thoroughly realized, so that dogmatic conclusions are as yet quite unwarranted. However, all investigators obtained generally encouraging results, while not claiming cures, and it seems that at least further trials of "Sulphetrone" are desirable, with the object of finding it a place, if warranted, in the treatment of selected cases of tuberculosis.

#### CHLOROMYCETIN.

RICKETTSIAL DISEASES have been disappointing in their response to the sulphonamides and penicillin just as they defied older forms of treatment. Among rickettsial diseases scrub typhus has made a particularly dramatic impression because of its relative frequency amongst service personnel in tropical areas, its severe effects in morbidity and mortality and the absence of specific treatment. It is natural then that interest was aroused by reports that a new antibiotic, thought to be effective against scrub typhus, was being investigated, but no clinical information has been available. Preliminary reports are now, however, coming to hand. Biological studies have been made by R. M. Smith *et alii*<sup>3</sup> on the substance, which was isolated from an unnamed soil actinomycete and has been named chloromycetin. According to the

report of these workers, the antibiotic has been obtained in crystalline form and found to contain nitrogen and non-ionic chlorine. It develops in several types of media, including meat broth, glycerol and molasses increasing the yield considerably. It is moderately active against Gram-positive bacteria and *Mycobacterium tuberculosis*, active against Gram-negative organisms, and inactive against yeasts and fungi. It gives no protection to laboratory animals against the majority of virus infections, malaria or syphilis, but produces remarkable effects in protecting chick embryos against rickettsial infection. The toxicity of the substance is similar to that of streptomycin, but it is only slightly soluble in water. It can be administered parenterally in propylene glycol solutions or orally. It is well absorbed from the intestine of the dog. Apparently it is inactivated in some fashion in the body, as only small amounts can be detected in the urine; it is possible that it is excreted by a route other than the kidneys. These workers have not yet evaluated the substance in man.

The clinical information at present available on chloromycetin has been summarized in a recent leading article in the *British Medical Journal*.<sup>1</sup> In a small series (treated by Smadel and others in Mexico) of three adults and one child suffering from epidemic louse-borne typhus and one child with murine typhus, benefit appeared to result from the use of chloromycetin, the most noticeable result in all cases being the rapid fall of temperature while the rash remained unchanged. No toxic reactions due to the drug were observed. The clinical effect of chloromycetin on scrub typhus is being investigated in Malaya by an American team headed by J. E. Smadel, who is working in collaboration with Lewthwaite and Savor at Kuala Lumpur. Preliminary results were announced at the International Congress of Tropical Medicine at Washington in May of this year. Twenty-five patients have so far received the drug, and twelve patients from the same area have been used as controls. Among those treated none has died and no complications have developed. The duration of fever after the first dose averaged thirty-one hours and the whole febrile period seven and a half days. Among the untreated controls one died, and this patient and one other had serious complications; the mean duration of fever was 18.1 days. At first large doses were given following previous experience with louse-borne typhus, but the dosage was gradually reduced. The results, however, were equally good. Half the patients were nursed under the relatively rough conditions in the hospitals attached to rubber estates. These reports are encouraging, though too limited as yet to be conclusive. The greatest interest attaches to the demonstrated activity of chloromycetin against rickettsiae, and it may well be that an effective agent against the important rickettsial group of diseases is in sight. Incidentally another similar antibiotic, aureomycin, has been isolated, and preliminary reports suggest that it, too, is active against rickettsiae.

#### DANGEROUS DRUGS.

ADVICE has been received from the New South Wales Chief Secretary's Department that the provisions for the control of dangerous drugs in the *Police Offences (Amendment) Act, 1908*, as amended, now apply to di-2-dimethyl-amino-4:4-diphenyl-heptane-5-one, known as "Amidone", "Methadon", "Dolophine" or other trade name, and to methylidihydro-morphinone, known as "Metopon" or other trade name, and to any preparation, admixture, extract or other substance containing not less than one-fifth per centum of these drugs. Corresponding regulations were recently made in regard to the drug known as pethidine, "Dolantin", "Demerol" or other trade name. The list of dangerous drugs is growing and will grow more, but practitioners in all States are urged to maintain vigilance in prescribing any of these drugs and to cooperate to the full in the very necessary control measures.

<sup>1</sup> *Ibidem*, July 31, 1948.

<sup>2</sup> *Ibidem*, July 31, 1948.

<sup>3</sup> *Journal of Bacteriology*, March, 1948.

<sup>1</sup> *British Medical Journal*, August 28, 1948.

## Abstracts from Medical Literature.

### THERAPEUTICS.

#### Vitamin E in Angina Pectoris.

D. H. MAKINSON, S. OLESKY AND R. V. STONE (*The Lancet*, January 17, 1948) describe the treatment of *angina pectoris* with vitamin E. Twenty-two patients having frequent attacks of typical anginal pain were treated. None had evidence of recent coronary thrombosis. A dose of fifty milligrammes of vitamin E was given thrice daily or phenobarbitone half a grain thrice daily or aminophylline 0.1 gramme thrice daily or calcium lactate five grains thrice daily. The patients did not know which drug they were taking. All were treated for three weeks. At the end of that time those patients receiving phenobarbitone appeared to benefit most, and those receiving vitamin E and aminophylline also claimed to have improved. The authors concluded that vitamin E was not of any therapeutic value in the routine treatment of *angina pectoris*.

#### Antithyroid Drugs in the Treatment of Hyperthyroidism.

J. M. KILGOUR (*The Canadian Medical Association Journal*, December, 1947) discusses antithyroid drugs in the treatment of hyperthyroidism. When thiouracil or its derivatives is administered in adequate dosage over a sufficiently long period of time, practically every case of thyrotoxicosis, whether Graves's disease or toxic nodular goitre, returns at least to a state of normal metabolism, and if maximal doses are continued myxoedema will eventually result. If smaller maintenance doses are continued, it has proved possible to maintain the metabolic state at normal levels. The optimum dose for complete inhibition with thiouracil is approximately 600 milligrammes given in three equally divided doses throughout the day, and the average maintenance dose is between 100 and 300 milligrammes. The effect of chemical thyroidectomy produced by the drug persists only while its administration is continued. The effect is not immediate, but it usually requires from two to three months to accomplish the desired result. Structural changes involving a marked hyperplasia with loss of colloid substance and increased vascularity occur in the thyroid gland as a direct result of depressed thyroid functions, and these changes are mediated through the pituitary gland. These changes in the thyroid gland can be reversed by iodine administration after withdrawal of the thiouracil. Thiouracil does not relieve the exophthalmos; and moreover it exhibits important toxic manifestations, of which severe leucopenia is one of the most common. About 3% to 5% of subjects manifest this complication, that is to say, a count of less than 3000 leucocytes per cubic millimetre. Frequent leucocyte counts and smears may detect early leucopenia, but do not predict agranulocytosis which may appear suddenly. Therefore the patient must be warned to be on the lookout for any febrile illness, sore throat or skin eruption, and to stop the drug forthwith and report if such should occur. The physician should insist on

frequent clinical examinations of a patient receiving the drug, and self-administration without supervision is to be deprecated. In the author's opinion, thiouracil is best reserved for the following specific purposes: (i) for recurrent thyrotoxicosis following thyroidectomy; (ii) for patients with severe toxic conditions, cardiac failure, or other complications such as iodine resistance; the drug should be used as a preliminary to operation until the basal metabolic rate is normal; (iii) for those cases in which operation is refused or is otherwise contraindicated. Propylthiouracil requires about one-quarter to one-third the dose, although the effect is less rapid. When given in doses of 150 milligrammes daily, propylthiouracil controls about 60% of cases, but larger doses of 200 and 300 milligrammes may be required. The effective maintenance dose may be as little as 75 milligrammes daily. It is less toxic than thiouracil. The relapse rate, even after nine months' treatment, is approximately 50% within five to six months of cessation of treatment. Patients with pressure symptoms should be treated by thyroidectomy as soon as possible, with pre-operative thiouracil if indicated. Patients with a pronounced enlargement of the thyroid show a high incidence of relapse, even after prolonged treatment, and will probably require thyroidectomy which is best not deferred. The incidence of relapse in males is very high and propylthiouracil is unlikely to produce prolonged recovery. The author states that, in the present state of knowledge of antithyroid drugs and in particular of propylthiouracil, they may best be employed in post-operative recurrences, as a pre-operative treatment for severe conditions which will require operation later, and as a definite method of treatment in subjects without marked thyroid enlargement, especially women. It is essential that these latter patients realize the necessity and are sufficiently cooperative to remain under surveillance at weekly intervals for the first two or three months and at one to two month intervals thereafter, and are conversant with the toxic potentialities of the drug. Patients with much enlargement, especially men, and possibly those with large or multiple adenomata, will probably ultimately require thyroidectomy, which should not be deferred once the disease is controlled. The low incidence of toxicity with propylthiouracil is encouraging, but should not relax vigilance. Only time can tell what the ultimate place of these drugs will be in the management of hyperthyroidism, but in the meantime the author does not consider that they constitute the final answer or that they will entirely replace operation. Possibly radioactive iodine may change the picture in the future, but meanwhile the antithyroid drugs provide a distinct forward step in the safe and effective control of thyrotoxicosis, as a pre-operative measure, and will probably render operation unnecessary in a fair proportion of selected cases.

#### Arthritis.

D. M. BAKER AND M. S. CHAYEN (*The Lancet*, January 17, 1948) discuss treatment of arthritis by intra-articular injection. Patients with severe osteoarthritis or rheumatoid arthritis of hips, knees and shoulders were treated by aseptic injection of one to ten milli-

litres of 2% (or less) solution of procaine in normal saline solution or lactic acid in 2% procaine solution. One or two days' rest of the joint followed, and later graduated movement and exercise. Of 52 patients, 16 were greatly improved and only 13 showed no improvement. Symptoms tended to recur at the end of two weeks. Injections were repeated three or four times at intervals of two weeks or more. Injection of too much fluid caused great pain. Sometimes effusion into the joint followed injection, but this if anything relieved pain. The nature of the fluid injected appeared to be unimportant, equally good results being noted with lactic acid, procaine and normal saline. The main benefit seemed to be due to the lubricating effect of the fluid.

#### Hæmophilus Influenzæ Meningitis.

A. L. HOYNE AND R. H. BROWN (*The Journal of the American Medical Association*, February 28, 1948) discuss the treatment of *Hæmophilus influenzae* meningitis. They state that repeated lumbar puncture for intrathecal treatment of this type of meningitis is unnecessary and harmful. They even quote figures demonstrating recovery of 26 out of 28 patients with *Hæmophilus influenzae* meningitis when treated with influenza antiserum. However, the purpose of this article is to report a series of 28 patients with *Hæmophilus influenzae* meningitis who were treated with streptomycin. In all cases diagnosis was made by lumbar puncture and by demonstrating *Hæmophilus influenzae* in smear and culture. Streptomycin was given in doses of 100 milligrammes every three hours intramuscularly for an average of five days. Sulphadiazine was also given in all cases for about three weeks. Several patients received treatment with serum also, but the authors consider that serum is not necessary if adequate doses of streptomycin and sulphadiazine are given. Two patients died in this series; these were two out of seven patients who were given intrathecal injections of streptomycin, which the authors consider are unnecessary.

#### Peptic Ulcer.

R. S. BOLES (*The Journal of the American Medical Association*, February 21, 1948) discusses treatment of peptic ulcer by modern surgical and medical means. He states that 1,500,000 persons in the United States of America suffer from peptic ulcer in ten years and that 10,000 die of it each year. He suggests calling the condition neuro-circulatory ulcer, and not peptic ulcer, and states that it is not due to pepsin and not due to excessive gastric acidity. In his opinion there is too much science and not enough humanity in the investigation of ulcer, and he considers that the mode of life should be investigated rather than local details of stomach function. Stress is laid on the hereditary aspect of ulcer, and consideration is asked of the part played by vascular disease and nervous influences and the effect of tobacco. The author states that ulcers are more common in spring and autumn and less common in summer. Medical treatment includes rest, diet, no alcohol, tea or tobacco, and a calm and imperturbable life. The author mentions new techniques, such as enterogastrone, a substance obtained from the small intestine of hogs. It decreases gastric secretion and mobility; given by injection six



times a week for three to twelve months it was said to give gratifying results, but there is no report as to the duration of the remissions in symptoms. An oral preparation is being tested. Another new treatment is with urogastrone, a depressant of gastric secretion obtained from human urine. This is just being investigated. Intragastric drip is a troublesome but reliable method of treatment and much has been used, but unsuccessfully, by itself. However, the author does not recommend any specific treatment. He discusses surgery very critically, in particular gastro-enterostomy, gastric resection and resection for hemorrhage. The last-mentioned operation has a high mortality rate and a high rate for recurrence of hemorrhage. As for vagotomy, the author states that it greatly disrupts the secretion and motor mechanisms of the stomach and has other serious defects.

## NEUROLOGY AND PSYCHIATRY.

### The Anatomy of Traumatic Epilepsy.

W. RITCHIE RUSSELL (*Brain*, September, 1947) has assessed the site of injury in two series of cases of head injury. In one series the injury was followed by epilepsy and in the other the injury was not complicated by epilepsy. His results showed that epilepsy followed an injury in any area of the brain, but was more frequent after injuries in the frontal and parietal zones.

### Sciatica and Low-Back Pain.

MURRAY A. FALCONER, MURRAY McGEORGE and A. CHARLES BEGG (*Journal of Neurology, Neurosurgery and Psychiatry*, February, 1948) discuss the mechanism of pain in sciatica and low-back pain. The cases considered were due to disk lesions. The low-back pain is presumed to be due to impingement of the sinu-vertebral nerve of Luschka. This is a tiny recurrent twig arising from the spinal nerve distal to the spinal ganglion; after uniting with a branch from the sympathetic chain, it reenters the spinal canal through the intervertebral foramen to supply the disk. Sciatica appears only when the disk prolapse is so situated that it impinges upon the nerve root in its extrathecal course at the level of the lower two lumbar intervertebral disks. Secondary changes of edema within the affected nerve root contribute further to the symptoms. In disk lesions the sciatic pain may lessen if this edema resolves. The authors suggest that sciatica and low-back pain should be treated conservatively, at first by rest; if this fails surgical treatment is necessary.

### Relation of Personality Problems to Onset and Progress of Multiple Sclerosis.

O. R. LANGWORTHY (*Archives of Neurology and Psychiatry*, January, 1948) discusses the relation of personality problems to the onset and progress of multiple sclerosis. He suggests that in a number of cases of multiple sclerosis emotional factors are important. He describes the case histories of four women. They show evidence of emotional immaturity with

neurotic relationships with the mother. As a consequence they chose a husband whom they thought intellectually and socially inferior to them in an apparent attempt to assume a dominating role. Sexual relationships were never satisfactory. These adjustment difficulties often were related to the onset or exacerbation of symptoms. The author suggests that vascular changes occurring in the brain at the time of emotional difficulty and upset could lead in turn to organic changes. He suggests that the psychological background should be examined in every case of multiple sclerosis, because treatment of this aspect can give the patient considerable help.

### Safety of Electric Shock Therapy.

WILLIAM KARLINER (*The Journal of Nervous and Mental Disease*, January, 1948), in an intensive survey of the literature of the neurological signs and complications of electric shock therapy, expresses the opinion that there is not sufficient evidence to indicate structural brain change. With proper evaluation of indications and contraindications no permanent damage is produced.

### Aphasia Studied in Patients with Missile Wounds.

F. SCHILLER (*Journal of Neurology, Neurosurgery and Psychiatry*, November, 1947) discusses the terminology and cerebral localization of aphasia. This work is based on the examination of forty-six war casualties with penetrating missile wounds of the brain resulting in some disorder of the speech function. The author shows that all aphasic disorders are of a mixed nature and that in all cases of true aphasia there is difficulty in word finding. Frontal lesions tend to impair most the speaker's initiative, the speed of his enunciation, the articulation of his words, and the inflection of his voice. In temporal lesions there was an impairment of understanding of spoken language, both of what the patient was saying and of what was said to him. Posterior-temporal and temporo-parietal lesions interfered mainly with the interpretation of the visual symbols of speech, reading and writing. In parietal lesions there was a disturbance of all those faculties related to orientation in space and appreciation of shape. The pattern of the word or proposition to be said, read, or written became distorted. The most highly organized intellectual aspects of speech function were affected by lesions of the posterior part of the Sylvian area. The author suggests that speech defects should be classified according to the anatomical lesion rather than to the nature of the aphasic manifestations.

### Sedation and Iwo Jima.

ELMER KLEIN (*The Journal of Nervous and Mental Disease*, January, 1948) has described the acute psychiatric war casualties which occurred in the battle of Iwo Jima, said to have been the bloodiest campaign in the Pacific area, and the marines' toughest fight in their history of one hundred and sixty-eight years. Amnesic reactions were common and nothing could be remembered for two or three days. Sedation was partly responsible. Headaches were frequent. The patients suffered from disturbed sleep and nightmares. Hysterical reaction occurred more commonly than in civilian prac-

tice. The major psychotic reactions included reactive depressions and schizophrenic episodes. The author records a gratifying rapidity of recovery; 50% were ready for duty when the hospital ship arrived at its base. He points out that the sheet-anchor of treatment was sedation and comments adversely on the abreaction methods of the well-known "Grinker" type. In his opinion fear is a normal reaction which still responds to the age-old therapy of sleep. The sufferer asks to forget and not to relive his emotional experiences.

### "Epanutin" in Epilepsy.

ROBERT G. R. BURROWS (*The Journal of Mental Science*, October, 1947) has observed the effect of "Epanutin" ("Dilantin Sodium") on 196 patients in Maghull Colony over a period of six years. The patients had previously been treated with bromide and phenobarbitone. The average optimal dose was one and a half grains in capsule three times a day, though sometimes four or five capsules daily were necessary; occasionally phenobarbitone half a grain to one and a half grains at night was included; children over the age of ten years tolerated adult doses. Following the treatment with "Epanutin" 65% of patients showed definite improvement, 16% total cessation of fits, 98% mental improvement without reduction of the number of attacks. Toxic symptoms occurred in 30% of cases, and included mental confusion 13%, hyperplasia of the gums 6%, and vertigo, diplopia and blurred vision 6%. Tremor, ataxia and vomiting were also noted.

### Musicogenic Epilepsy.

DAVID SHAW and DENIS HILL (*Journal of Neurology, Neurosurgery and Psychiatry*, August, 1947) discuss a case of musicogenic epilepsy. In this patient a convulsive seizure followed different kinds of music within five minutes. The electroencephalographic tracings taken before and during the seizure are analysed, and the possible mechanisms, including emotional factors, of seizure production are discussed.

### Cerebral Symptoms in Thromboangiitis Obliterans.

DAVID PERK (*The Journal of Mental Science*, October, 1947) discusses the historical recognition of *thromboangiitis obliterans*. He states that the literature provides evidence that any neurological symptom may be produced by involvement of the cerebral vessels: spasms, tics and convulsions, palsies and paralyses, hemianopia, aphasia, loss of consciousness and mental symptoms, to quote from a few of the reported cases. Neurological and mental symptoms may precede, though they usually follow, manifestation of the disease in the extremities and other parts of the body. Cerebral symptoms in the early stages tend to be transitory and recurrent, later permanent. The case history of a patient followed for sixteen months is cited; the condition was variously diagnosed as schizophrenia, mania and epileptic psychosis. The author believes that the psychosis was precipitated by transitory spasm of one or more cerebral vessels; later the disease became more evident and was associated with diplopia, dysarthria, epileptiform fits and gangrene of the feet.

## British Medical Association News.

### MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the University of Western Australia and at the Western Australian Branch Library, Perth, on August 12, 13, 14 and 20, 1948, Sir Henry Newland, the President, in the chair.

#### Representatives.

The following representatives of the Branches were present:

**New South Wales:** Dr. A. J. Collins, D.S.O., M.C., Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. C. Thomas (substituting for Dr. A. J. Murray).

**Queensland:** Dr. A. E. Lee, Dr. H. W. Horn.

**South Australia:** Sir Henry Newland, C.B.E., D.S.O., Dr. R. J. Verco.

**Tasmania:** Dr. T. Giblin, Dr. J. L. Grove.

**Victoria:** Dr. T. E. Victor Hurley, C.B., C.M.G., V.D., Dr. H. C. Colville, Dr. C. Byrne.

**Western Australia:** Dr. F. W. Carter, Dr. Leigh Cook (substituting for Dr. N. M. Cuthbert).

#### Minutes.

The minutes of the meetings of the Federal Council of March 11, 12 and 13 and of May 15 and 16, 1948, which had been circulated among members, were taken as read and signed as correct.

#### Annual Report of the Federal Council.

The annual report of the Federal Council for the year ended June 30, 1948, was received and adopted.

#### Finance.

The financial statement and balance sheet of the Federal Council as at June 30, 1948, and of the Australasian Medical Congress (British Medical Association) fund account were received and adopted.

Dr. W. F. Simmons, the honorary treasurer, raised the question of the *per capita* payment by the Branches to the Federal Council for the year 1949. He placed before members a statement setting out an estimate of the expenditure of the Council in the immediate future and said that it was quite possible that at the end of the year the Council might find itself without funds. He wanted to know what arrangements he would make if this happened. Dr. A. J. Collins suggested that money could be obtained from the organization fund, but Dr. Simmons doubted whether the organization fund was a suitable source. Dr. H. C. Colville said that the present year was extraordinary, but he did not think that another meeting of the Federal Council would be necessary before the end of the year. He moved that if extra funds were needed before the end of the year, the treasurer should be authorized to draw on the organization fund. This motion was seconded by Dr. A. J. Collins. Dr. R. J. Verco thought that the money needed might be borrowed from the organization fund and repaid later or when the next *per capita* payments were made by the Branches. Dr. F. W. Carter agreed with Dr. Simmons. Dr. C. Byrne asked how the money in the organization fund was to be spent. When Dr. Simmons replied that it would be spent on organization of the affairs of the Branches, Dr. H. C. Colville suggested that it would be difficult to find an object on which to spend the money that would benefit only those members of the profession who had subscribed it. It was eventually resolved that any reasonable deficit in the Federal Council's bank balance during the remainder of the year 1948 should be borrowed from the organization fund and refunded from the general fund of the Federal Council received by capitation payments in 1949.

Dr. Simmons then discussed the capitation rate for 1949. He enumerated the matters to be considered by the Federal Council which would increase the expenditure of the Council. These included the whole question of the secretariat, the representation of the Federal Council at the inauguration of the British Commonwealth Medical Council and at the annual meeting of the World Medical Association, and the suggested appointment of an assistant to the General Secretary. After discussion, it was resolved that consideration should be deferred to a later stage in the meeting when the matters enumerated by Dr. Simmons had been discussed.

It was resolved later that the *per capita* payment from the Branches for 1949 should be twenty-one shillings.

The General Secretary reported that a request had been received from the Tasmanian Branch for a grant of £200 from Federal Council funds for organization purposes. He said that he had recently visited the Tasmanian Branch and had discussed the affairs of the Branch with Dr. J. B. Hamilton, the President, and with other members of the Council. The Tasmanian Branch realized that it would be necessary to increase the Branch subscription and steps were being taken towards that end. In the meantime the General Secretary indicated that the request was reasonable and should receive sympathetic consideration. It was resolved that the grant should be made.

The financial statement of the Federal Organization Fund was submitted by Dr. W. F. Simmons, the treasurer, and received.

#### The Secretariat.

At the previous meeting of the Federal Council the establishment of a full-time secretariat was discussed at the instance of the Victorian Branch and the Council resolved: "That the General Secretary devote the whole of his time to the Federal Council." Soon after the adoption of this resolution, Dr. H. R. R. Grieve gave notice that, at the following meeting, he would move that the resolution should be rescinded.

Dr. Grieve therefore moved the motion standing in his name and drew attention to a statement that had been drawn up for the consideration of the Federal Council by the New South Wales Branch Council. The Council also had before it a statement drawn up by the General Secretary.

In the New South Wales Branch statement it was pointed out first of all that Dr. J. G. Hunter had an unrivalled knowledge of the affairs of the New South Wales Branch and that, since the membership of the Branch represented more than 40% of the whole Commonwealth membership of the Association, this was of importance to the effectiveness of the Federal Council policy at large. If Dr. Hunter was to be transferred to the Federal sphere, his secretary, Miss H. Cameron, would have to be transferred with him, and the New South Wales Branch found it impossible to free Miss Cameron. The introduction of *The Pharmaceutical Benefits Act* had made great demands on the Federal Council organization which had functioned with unqualified success. To disjoin this framework of system and personnel at the present stage could only be regarded as both unnecessary and undesirable. Under existing arrangements the Federal Council was able to use all the facilities of the New South Wales Branch, including sometimes the services of the whole of the Branch staff. Even if Miss Cameron was transferred to the Federal secretariat and a deputy was appointed, it would not be possible for the two persons to cope with the Federal Council work during busy periods. If the Federal secretariat was to be a separate entity, it would be necessary for the Federal Council to find fresh accommodation, and this was no easy matter. The financial aspect had also to be considered. At the present time the annual expenditure of the Federal Council was approximately £3000 a year; the establishment of a full-time secretariat would raise the expenditure to £4500. The sending of two delegates to the inauguration of the British Commonwealth Medical Council would mean an additional cost to the Federal Council of about £1200, although the Council was bearing only half the cost of sending one of the delegates. The submission of the Western Australian Branch that assistants should be appointed to understudy Dr. Hunter and Miss Cameron was sound and the question was whether the time had arrived for the appointment of assistants.

The General Secretary in his memorandum pointed out that the present arrangement was economical from the Federal Council's point of view. The New South Wales Branch had provided office facilities at a nominal cost and the arrangement had the advantage that during busy periods it was possible for the Federal Council to utilize the services of three or four members of the New South Wales Branch office staff. Miss Cameron was in charge of the New South Wales Branch's clerical staff, and she had an intimate knowledge of the Association's work. It was clear that while the New South Wales Branch was pleased to allow Miss Cameron to continue her part-time service with the Federal Council, it would not agree to her whole-time transfer. It would be very difficult for a newcomer to become familiar with the Federal Council's work unless she had had Branch office experience. One person could not cope with the Federal Council's office work, and a considerable increase in staff would be required, which, of course, meant increased cost. If a full-time secretariat was to be set up, office accommodation would have to be found and this would be both difficult

and costly. The General Secretary concluded that, having regard to all the circumstances, financial and otherwise, he thought that the most advantageous and most satisfactory way of dealing with the question of a full-time secretariat was: (a) to appoint full-time assistants to himself and Miss Cameron; (b) to allow the present arrangement with the New South Wales Branch regarding himself and Miss Cameron to continue.

Dr. A. J. Collins seconded Dr. Grieve's motion and said that it was an advantage that the General Secretary of the Federal Council should also be in close touch with a large body of Branch members. Dr. F. W. Carter referred to the Federal Council's discussion of the subject in 1943 and to the opinions then voiced in regard to the need for periodical visits to the Branches by the General Secretary. He could understand the attitude of the New South Wales Branch. His own Branch had authorized him, in view of the New South Wales Branch's statement, to vote for rescission. At the same time, the Western Australian Branch thought that the ideal of a full-time secretariat should be kept in mind. Dr. Victor Hurley said that there was no question of the Federal Council's going back on the ultimate ideal. He pointed out that health in Australia had become largely the concern of the Federal as opposed to the State authority, and this was an important argument in the favour of the ultimate aim. Dr. Hurley was prepared to accept Dr. Carter's point of view. Dr. Leigh Cook said that Dr. Carter had stated the Western Australian Branch Council's point of view, but that as he was there in the place of Dr. N. M. Cuthbert, he wished, at Dr. Cuthbert's request, to point out that the Federal Council's resolution of the previous meeting, which it was proposed to rescind, contained no reference to time. Dr. Cuthbert thought that, for this reason, the resolution could stand, and that rescission would be a retrograde step. Dr. T. Giblin said that the Tasmanian Branch had left the matter to its representatives, with the proviso that the principle of the establishment of a full-time secretariat should be preserved. Dr. C. Byrne said that he had no sympathy with the New South Wales Branch's reluctance to free Dr. Hunter, but he was concerned with the questions of accommodation for the new secretariat and with the expense. After further discussion the motion for rescission was put to the meeting and carried.

Dr. C. Byrne thought that the policy of the establishment of a full-time secretariat should be reaffirmed, and gave notice of motion as follows:

That the policy of the Federal Council for a full-time federal secretariat be reaffirmed, and that the date of its implementation be discussed at the meeting of the Federal Council in the second half of 1949.

Dr. F. W. Carter dealt with a notice of motion standing in his name:

That immediate action be taken to strengthen the secretariat by the appointment of the following additional officers: (a) a whole-time assistant to the General Secretary, (b) a whole-time assistant to Miss Cameron.

He thought that action should be taken at once, and formally moved the motion. He said that a long apprenticeship would be needed by a newcomer. Dr. H. R. R. Grieve asked what inducement could be offered to attract the right kind of person. He maintained that a newly appointed assistant should not have the right of succession on the retirement of the General Secretary. He thought that the appointment should be surrounded by safeguards. A good salary should be offered and a man chosen who had had experience of practice. Dr. A. E. Lee said that there were many points of view to be considered. One of these was whether the apprenticeship should be served solely in the service of the Federal Council or with one of the Branches. He thought that more of the Branches should appoint full-time medical secretaries. It might be possible for arrangements to be made for the appointee to work for a Branch as well as for the Federal Council. Dr. H. C. Colville said that he held somewhat the same views as Dr. Lee had expressed. The proposal was that work at present being done by two persons should be done by four, and two of these should be understudies. He asked whether there was enough work for four persons. Dr. A. J. Collins feared that Dr. Hunter's health might be sacrificed by his unselfish work for the Federal Council. It might be difficult to find a man, but not necessarily. He suggested that a small committee should discuss the matter and report back to the Federal Council at a later stage of the meeting. Dr. Leigh Cook was doubtful whether training in a Branch office was best for work in the Federal sphere. Dr. H. W. Horn agreed with Dr. Cook that there might be danger in training in a

Branch office. If an appointee was sent to the Queensland office for training, Dr. Horn could imagine that the same conditions as were prevailing at present might arise and that the Queensland Branch might not want the newly trained man to go. In reply to a question by Dr. C. Byrne whether the appointment of an assistant to Miss Cameron would relieve him to any great extent, Dr. Hunter answered no. No one on the clerical side could relieve him. Dr. A. J. Collins moved that a special committee comprising the President, Dr. Victor Hurley, Dr. A. E. Lee, Dr. F. W. Carter and Dr. W. F. Simmons should discuss the appointment of an assistant to Dr. Hunter and report to the Federal Council later on in the meeting. In reply to a question by Dr. F. W. Carter, Dr. Collins said that the committee should tell the Council how and where to employ an assistant and what payment he should receive.

At a later stage in the meeting the committee presented its report and recommended that an assistant general secretary, who should be a medical practitioner, should be appointed; that the duties of the assistant general secretary should be such as were from time to time determined by the Federal Council; that the assistant general secretary should be a full-time officer of the Federal Council; that the appointment should not necessarily carry the absolute right of succession; that the applicant should preferably have had experience of private practice and not be older than forty years. In regard to conditions of service, the committee recommended that the applicant should be appointed on probation for one year and that his commencing salary should be £1250 per annum, plus superannuation rights on confirmation of appointment, plus adjustment for the cost of living to be determined annually by the Federal Council and with periodical increments for satisfactory service. The committee thought that there should be three months' notice of termination of the appointment on either side and that the annual leave should be four weeks.

In regard to an assistant to Miss Cameron, the committee recommended that a full-time assistant should be appointed and that terms and conditions should be left in the hands of the honorary treasurer and General Secretary. The committee further recommended that the New South Wales Branch should be asked to provide accommodation for the newly appointed assistants. The committee recommended that a committee consisting of one member of the Federal Council from each State should scrutinize the applications and decide on those candidates with whom a personal interview was desired, the final appointment being made by the Federal Council. The committee thought that the position of assistant general secretary should be advertised forthwith and that applications, together with credentials, should be forwarded to the General Secretary not later than December 31, 1948. The Federal Council discussed the recommendations of the committee and accepted them.

#### The Reservation of a Site for the Federal Council at Canberra.

The General Secretary reported that in May, 1948, he had received from the Surveyor-General and Chief Property Officer a letter in which he referred to correspondence which had passed between the Federal Committee and the Federal Capital Commission in the years 1927 and 1928 concerning the reservation of a site for the British Medical Association at Canberra. The Surveyor-General asked that he should be informed at an early date of the wishes of the Association regarding the proposal and the acceptance by the Federal Council of the lease of an area for building purposes. The General Secretary read copies of the correspondence of 1927 and 1928 which showed that in 1928 the Federal Committee had asked for an acre of land to be reserved for the British Medical Association in Australia on the same conditions as those granted to the College of Surgeons of Australasia. A reply had been received on September 18, 1928, from the secretary of the Federal Capital Commission stating that the Federal Committee's request was receiving consideration. Since then no further communication had been received. In discussion it was pointed out that there were certain conditions attached to the granting of a lease at Canberra, and it was resolved that the matter should be left in the hands of the General Secretary and that he might obtain further information from the Commonwealth authorities. At a later stage of the meeting it was resolved that in view of further information obtained the matter should be left in the hands of the President.

#### Medical Officers' Relief Fund (Federal).

On behalf of the trustees of the Medical Officers' Relief Fund (Federal), Dr. W. F. Simmons presented a report for the year ended June 30, 1948. He said that, during the



previous twelve months, the trustees had received three applications for grants. That this could happen after the fund had been established for thirty years was important when consideration was given to the fund that had been established during the recent war. Dr. Simmons also explained that four loans were still outstanding. One had been written off during the previous year on account of the death of the debtor. The report was received.

#### Federal Medical War Relief Fund.

On behalf of the trustees of the Federal Medical War Relief Fund, Dr. W. F. Simmons presented the report for the year ended June 30, 1948. This report showed that the total assets at June 30, 1948, amounted to £20,492. So far three claims for financial assistance had been made. One applicant had been granted a loan of £750 free of interest and repayable by ten half-yearly instalments of £75 each. The other two applicants, being widows of medical officers killed in action, had been granted regular weekly allowances of £2 and £1 respectively as a gift. Dr. W. F. Simmons said that objections had been raised by certain New South Wales members to the inclusion of the word "Relief" in the title of the fund. This raised the question of the finding of beneficiaries who might be unwilling to apply for relief. Dr. F. W. Carter asked how many war widows there were and said that the only thing to do was to communicate with them. Dr. Simmons replied that eighty-four medical officers had died on full-time service. It was the work of the local committees of the fund to discover suitable beneficiaries. Dr. H. R. R. Grieve pointed out that the funds were not being spent and added that the worst thing that could happen to such a fund was that the money should not be spent. Dr. T. Giblin said that the local committee in Tasmania had investigated every case and that no one needing help had been found. It was resolved that the Federal Council should ask the local committees of management in each State to supply the trustees of the fund with a list of the names of widows and dependants of deceased ex-service medical officers in their States, and also a confidential report of the financial position of those persons entitled to assistance from the fund.

The Federal Council also had before it a letter which the General Secretary had received from Dr. Angus Murray, of Sydney, in which he stated that it should not be necessary for widows to apply for assistance, but that it was the duty of the profession to keep in touch with them and to advise the trustees of the fund of any matter in which assistance would further the object of the fund. Dr. Murray had in mind particularly the future of the children concerned. He asked that consideration should be given to a scheme for the financing of endowment policies for these children, so arranged that they would mature at a period likely to be of service to them. Dr. Murray thought that if the present terms of trusteeship made such a scheme impracticable, consideration should be given to the formation of a new fund and that subscriptions should be invited to it forthwith. It was resolved that the trustees of the Federal Medical War Relief Fund should be informed that the Federal Council approved in principle of Dr. Angus Murray's proposal and that they should be asked to give effect to such proposal in a manner consistent with the advice given by the trustees' solicitors.

#### Appointment of Major-General F. Kingsley Norris as Director-General of Medical Services.

The General Secretary drew attention to the recent appointment of Major-General F. Kingsley Norris as Director-General of Medical Services. The Federal Council resolved to offer its congratulations to General Norris.

#### Sir John Newman Morris.

The General Secretary reported that on behalf of the President and members of the Federal Council, he had congratulated Sir John Newman Morris on the honour of knighthood recently conferred on him by His Majesty the King.

#### International Congress on Industrial Medicine.

The General Secretary reported that he had received a notice that the Ninth International Congress on Industrial Medicine would be held at London on September 13 to 17, 1948.

#### Australasian Medical Congress (British Medical Association).

The General Secretary reported that he had been requested by Dr. D. E. Copping, Press Liaison Officer, for a ruling

whether or not the Press was to be permitted to publish the names of speakers on scientific subjects at the sixth session of the Australasian Medical Congress (British Medical Association), which was to be held in Perth during the following week. Dr. Keith Barry, the Federal Director of Programmes for the Australian Broadcasting Commission, was particularly interested in this matter. Dr. H. R. R. Grieve said that it was desired that the name of individual members of congress might be published if public reference was made to their contributions. He found that amongst certain members of the public there was an impression that the congress was mainly a medico-political affair. That idea should be killed. Someone had made the suggestion that only the names of public medical officers should be allowed to be published, but this in Dr. Grieve's opinion would give rise to a false impression. He moved that permission should be given for the publication and use in broadcasting of the names of speakers on scientific matters at the sessions of congress. This motion was carried.

#### Vice-Presidents.

The General Secretary reported that invitations to act as vice-presidents had been accepted by the following: Dr. H. W. Horn, Dr. A. J. Metcalfe, Dr. E. H. M. Luke, Dr. Hector Stewart and Brigadier W. H. Blinman Bull.

#### Honorary Members.

The following were appointed honorary members of congress: the Reverend John Flynn, Professor N. S. Bayliss, Dr. J. G. Hunter and Dr. H. Berney.

#### Overseas Representatives.

The General Secretary announced that Professor Ransome had been nominated by the Malaya Branch of the British Medical Association as its representative and that Professor Frank Walsh was acting as representative of the American Medical Association.

#### The Conferring of Honorary Degrees.

The General Secretary informed the Federal Council that the University of Western Australia had decided to confer the honorary degree of Doctor of Science on Sir Henry Newland, Professor J. C. Spence, Professor Frank Walsh and Professor F. M. Burnet.

#### Date and Place of the Seventh Session.

The General Secretary said that Dr. W. F. Simmons had given notice of motion that the Seventh Session of the Australasian Medical Congress (British Medical Association) should be held in Brisbane in 1950. He added that he had received an invitation from the Queensland Branch for the holding of the Seventh Session in Brisbane in 1950. Dr. W. F. Simmons moved the motion standing in his name and it was carried.

#### Australasian Medical Publishing Company, Limited.

The General Secretary reported that a list of members of the British Medical Association in Australia had been published in July, 1948, by the Australasian Medical Publishing Company, Limited.

#### British Medical Association.

##### Empire Medical Advisory Bureau.

The General Secretary reported that he had received a letter from Dr. H. A. Sandiford, the Medical Director of the Empire Medical Advisory Bureau, setting out the objects of the bureau and the various ways in which it could be of assistance to members of the Association. The bureau was described in a leading article of this journal on July 3, 1948.

##### British Commonwealth Medical Council.

Reference was made to the inaugural meeting of the British Commonwealth Medical Council to be held in London on September 15 and 16, 1948, and the General Secretary said that he had received a letter from the Parent Body asking for suggestions for matters to be included in the agenda. During discussion it was decided that the question of reciprocity in the matter of medical registration between various parts of the British Commonwealth of Nations might be mentioned. Other matters suggested were the periodical exchange of medical teachers and the furtherance of closer relations in post-graduate teaching. The Federal Council also resolved to recommend to the inaugural meeting that the holding of meetings of the Council in the constituent countries of the British Commonwealth should be considered.

The General Secretary said that the Federal Council was entitled to three representatives. The two already appointed were Dr. A. J. Collins and Dr. Mervyn Archdall. The name of Dr. Athol Quayle, of Brisbane, had been suggested as that of the third representative and this suggestion was adopted by the Federal Council.

#### The Australasian Association of Psychiatrists.

The General Secretary read a letter from the Australasian Association of Psychiatrists in which closer cooperation between that body and the British Medical Association was invited. It was stated that, although the Association of Psychiatrists was still of the opinion that affiliation with the British Medical Association was not practicable, it would welcome members of that Association at any clinical meetings of general interest. The suggestion was made that it might be possible to advertise such clinical meetings in circular letters sent to members of the British Medical Association in each State. In reply to a question the General Secretary said that the psychiatrists had formed an association outside the ambit of the British Medical Association because of their desire to include among their members psychiatrists resident in New Zealand. This gave rise to a general discussion on the subject of special associations of medical practitioners.

Dr. C. Byrne thought that the formation of bodies outside the ambit of the British Medical Association should be discouraged. He said that as smaller associations became bigger and bigger, so their ideas became bigger and bigger, and they might be tempted to engage in medico-political activities. The President suggested that it might be wiser to talk about encouraging special groups of practitioners to remain within the fold of the British Medical Association rather than to suggest that they should be discouraged from going outside it. Dr. Byrne did not agree with this idea and moved a motion to the effect that the Branches should be informed that in the opinion of the Federal Council the formation of bodies outside the ambit of the British Medical Association should be discouraged. The motion was carried. On the question of the indulgence of outside associations in medico-political activities, Dr. H. C. Colville said that the greatest possible tact would be needed in anything that was done. After discussion it was resolved that special bodies outside the ambit of the British Medical Association should be communicated with and asked to refrain from medico-political decision and action. The Federal Council finally recorded its approval of the request of the Australasian Association of Psychiatrists for closer cooperation in regard to clinical activities.

#### The Principles of Medical Ethics.

The General Secretary reported that a request had been received from the Tasmanian Branch for copies of the principles of medical ethics which had been formally adopted by the Federal Council as the common code of ethics for the profession throughout Australia. He said that copies had not been printed, chiefly because it was not known how many copies would be required. After discussion, in which it was clear that some of the Branches did not realize that the code of ethics adopted by the Federal Council was the code for the whole of Australia, it was resolved that copies should be printed and furnished to the Branches desiring them, the cost being borne by those Branches.

#### Report of the Parent Body on Medical Education.

The General Secretary reported that he had received from the Parent Body a copy of its report on medical education. This report was referred to in a leading article in this journal in the issue of June 19, 1948. The General Secretary said that the report had been published for the Association by a British publishing house and that copies would soon be available in Australia.

#### National Health and Medical Research Council.

##### Twenty-Fourth Session.

The General Secretary reported that he had received an official copy of the report of the twenty-fourth session of the National Health and Medical Research Council, held in Sydney on November 12, 1947.

##### Twenty-Fifth Session.

The Council had before it a report by Dr. W. F. Simmons, Federal Council representative, of the twenty-fifth session of the National Health and Medical Research Council, held at Canberra on May 18 and 19, 1948. Discussion took place on a reference in one of the resolutions on tuberculosis to "Public Health Authorities". Dr. Simmons was asked to obtain clarification of the phrase.

#### The Federal Council's Representative.

The General Secretary pointed out that Dr. Simmons's term of three years as Federal Council representative on the National Health and Medical Research Council would terminate on December 31, 1948. Dr. Simmons had served as representative for two periods of three years. The Federal Council appointed Dr. Simmons as its representative for a further term of three years commencing from January 1, 1949.

Dr. H. C. Colville referred to the valuable work that had been done by Dr. Simmons as the Federal Council's representative on the National Health and Medical Research Council, and particularly to the reports furnished by him after every meeting. On this there was general agreement and the Council determined to place on record its appreciation of Dr. Simmons's service.

#### World Medical Association.

The General Secretary reported that a communication had been received from the World Medical Association to the effect that at a council meeting held in New York in April, 1948, Dr. Louis H. Bauer had been appointed Secretary General.

He also reported that he had received a questionnaire dealing with the advertisement and sale of secret remedies and appliances. He had completed this questionnaire and returned it to the Association.

A council meeting of the World Medical Association had been held in New York on April 26 to 29, 1948, and after this meeting a preliminary statement of actions of the council and minutes of the council meeting had been received. The General Secretary drew attention to certain matters arising from these minutes. One matter had to do with an attack on medical installations and personnel which had taken place outside Jerusalem on April 13, when a medical convoy of eleven vehicles was attacked and fifty-six Jews were killed and wounded during a seven-hour onslaught. The Council of the World Medical Association adopted certain resolutions in respect of this incident. The Federal Council resolved that its representatives to the next meeting of the Association should be instructed to report on this matter on their return to Australia. A second subject dealt with had to do with the resettlement of refugee doctors. The General Secretary said that information in regard to the entry of refugee doctors into Australia and their registration was being collected for the use of the Federal Council's representatives. He gave details of some of the figures already obtained. The Federal Council resolved that the matter should be left in the hands of its delegates and that they should be instructed to report on their return to Australia.

In regard to the place of the third annual meeting of the World Medical Association in 1949, the Federal Council decided to leave this matter in the hands of its delegates, who were to be instructed to report on their return to Australia.

The General Secretary said that a communication had been received from the World Medical Association suggesting that exchange holiday visits might be arranged between members of doctors' families in different countries. It was decided that this letter should be sent to THE MEDICAL JOURNAL OF AUSTRALIA for publication.

#### Appointment of Delegates to Geneva Meeting.

It was resolved that Dr. A. J. Collins and Dr. Mervyn Archdall should be appointed delegates to attend the second annual meeting of the World Medical Association at Geneva on September 8 to 11, 1948.

#### Publicity.

The members of the Publicity Committee of the Federal Council were reappointed as follows: Dr. H. R. R. Grive, Dr. W. F. Simmons, Dr. A. J. Collins and Dr. H. C. Colville.

The General Secretary said that he had received a copy of a resolution of the Victorian Branch Council stating that the Victorian member of the Publicity Committee should be consulted on all matters pertaining to publicity. The General Secretary gave an assurance that this would be done. At the same time, he pointed out that it would not always be possible to do this as sometimes matters for the Press had to be decided at a moment's notice.

The General Secretary said that he had received a letter from the South Australian Branch requesting that consideration should be given to the appointment of a public relations officer. He read a letter which had been sent by the New South Wales Branch Council to its local medical associations on the question of publicity in connexion with *The Pharmaceutical Benefits Act*.

### The Pharmaceutical Benefits Act, 1947.

The General Secretary referred to the conference held with the Minister for Health at Melbourne on July 3, 1948. He dealt with correspondence that had passed between the Branches and the Federal Council prior to and following the conference. He said that he had received from the Minister four copies of a verbatim report of the conference and had had copies printed and circulated among members of the Federal Council and Branch Councils.

The General Secretary said that he had received a letter from the Minister dated July 20, 1948, with which he enclosed copies of a proposed new prescription form. The form was slightly larger than that designed under the regulations of the act and allowed more space for the writing of prescriptions. The Minister thought that this size would best serve the convenience of doctors visiting patients in hospital and in their homes. It was intended that the doctor should be able to print his name and address at the head of the form and to include the telephone number and other information such as surgery hours. A space was ruled off on the left-hand margin and this was intended for use by the pharmacist and by the department. At the foot of the duplicate form appeared the words "Pharmaceutical Benefits Act, 1947". The Minister indicated that it was intended that forms would be supplied by the Commonwealth and any over-printing or stamping would be a matter for the doctor's choice. The alterations proposed in regard to penalty clauses would apply to the new form.

The General Secretary said that the Minister's letter had been submitted to the Branches. The New South Wales Branch replied that the suggested alterations were unacceptable. The Tasmanian Branch replied that it was not prepared to accept the Minister's proposal. The Queensland Branch found the proposal unacceptable and the South Australian Branch replied that the proposal did not alter the position. The Victorian Branch in its reply stated that there was no change in the attitude of Victorian members to the act. The Western Australian Branch rejected the proposal.

The President pointed out that he had promised to let the Minister know the decision of the Branches following the conference of July 3, 1948. After discussion, the Federal Council appointed the following as a committee to draw up a letter for presentation to the Council at a later stage of the meeting: Dr. A. J. Collins, Dr. H. C. Colville, Dr. C. Byrne, Dr. H. Leigh Cook and Dr. H. R. R. Grieve. On the last day of the meeting the Council approved the adoption of the following letter for transmission to the Minister:

Dear Mr. Minister:

The Federal Council of the British Medical Association in Australia in session in Perth has considered the matters arising out of the conference in Melbourne on 3rd July, 1948.

It is to be regretted that the Government has not appreciated what the Federal Council has continually submitted, *viz.*, the importance to the patients' interests of the right to receive free those medicines which, in their doctors' judgement, they need. The Federal Council wishes again to inform you that the cooperation of the medical profession in the working of the act can be assured once the Government agrees to allow, for the purposes of benefits under the act, prescribing on the doctors' own forms of drugs within the British Pharmacopoeia and any others that may be mutually agreed upon, in any dose and in any combination. Prescriptions for this purpose could be written upon doctors' private forms, uniform in size, in duplicate and bearing the name and address of both the patient and the doctor.

In accordance with the undertaking given to you at the conference on 3rd July, 1948, your proposed amendments to the *Pharmaceutical Benefits Act*, which do not envisage the acceptance of this offer or the elimination of any of the three main objectionable features of the act, have been submitted to all State Branches of the British Medical Association and through them to every member of the Association in Australia. Having received replies from the Branches, the Federal Council is now in a position to state that no change in the attitude of members of the medical profession has taken place as a result of the proposed amendments. The Federal Council wishes to make it clear that the question of voluntary cooperation in the working of the *Pharmaceutical Benefits Act* is a matter for the decision of the individual member of the medical profession, voiced through the Federal Council.

In view of the fact that there is no dispute on the general principle that the people of Australia should receive free medicine, the Federal Council ventures to

suggest that it would be wise for the Government to abandon the unnecessary and intolerable formalities and restrictions which are alone preventing the issue of free medicine to the people.

Finally, the Federal Council wishes to inform you that it reserves the right to make public the contents of this letter.

Faithfully yours,

H. S. NEWLAND,  
President.

A reference was made to an address given by the Minister to the Senate and broadcast on the national network on June 15, 1948. The General Secretary told the Council that he took grave exception to remarks made by the Minister about him in the address which were based on a statement which appeared in the Press. He described the Press statement as incorrect and the Minister's remarks as damaging to him personally. It was resolved that the Minister should be communicated with to the effect that he had made in the Senate on June 15, 1948, remarks broadcast throughout Australia and concerning the General Secretary of the Federal Council which were based on an incorrect Press statement and which were damaging to the General Secretary of the Federal Council; it was also resolved that the Minister should be asked to take adequate steps to bring before the public the fact that his remarks had been based on a statement which was incorrect.

The address by the Minister was further considered and the Federal Council resolved that the publicity committee should be empowered to draw up an annotated statement in reply to the Minister's address and that the statement should be circulated amongst members. It was also resolved that the Publicity Committee should be empowered to draw up a protest to the Minister in the strongest possible terms against this type of propaganda and also that the Minister should be informed that the Federal Council was strongly of the opinion that, unless these statements were corrected, they would strongly prejudice future discussions between the Minister and the Federal Council.

A request was received from the Western Australian Branch that copies of speeches and statements made by Commonwealth Ministers on matters affecting the profession should be forwarded to Branch Councils. The General Secretary pointed out that it would not be possible to do this. *Hansard* did not record speeches until about three weeks had elapsed after their delivery and even then permission might have to be obtained to comply with the request of the Western Australian Branch.

The General Secretary reported that a letter had been received from the New South Wales Branch suggesting that a consideration might be given to the establishment of a fund to reimburse medical practitioners whose incomes had been or might be affected adversely by allegiance to the policy of the Federal Council. The General Secretary said that he had referred the matter to the Branches. The Queensland Branch had agreed with the suggestion; the South Australian Branch thought it was impracticable; the Tasmanian Branch endorsed the proposal and the Victorian Branch left the matter in the hands of its delegates. During discussion it was pointed out by Dr. A. J. Collins that there was no urgency in the matter and that it would be satisfactory to have a fund in existence if it was needed. The Federal Council resolved that the establishment of a fund to assist medical practitioners who suffered financially because of allegiance to the policy of the Federal Council should be authorized.

### Medical Planning.

#### National Medical Service.

The General Secretary reported that he had received from the Tasmanian Branch an analysis of the replies to a questionnaire which had been sent to Branch members on the subject of a national medical service. He also reported that he had received from the South Australian Branch a copy of a pamphlet issued to members informing them of various reports published on the question of medical planning.

#### Hospital Services.

The General Secretary said that he had received from the Tasmanian Branch a letter dealing with the payment of visiting staffs to public hospitals. The Tasmanian Branch had received from the Department of Public Health, Hobart, a letter in which it was stated that the department had been in communication with the Federal Minister for Health, Canberra, and that a reply had been received. In this letter the Minister had stated that it was desirable that sessional fees paid to specialists at public hospitals in Tasmania should conform to the remuneration paid elsewhere in Australia. At the Brisbane General Hospital and the Children's



Hospital, Brisbane, the rate of remuneration for one session of three hours in each week was £200 per annum for a senior specialist, with four weeks' leave on full pay, but no sick leave. The remuneration of a junior specialist for one session per week of three hours was £150 per annum and for assistants £125. The Minister for Health advised that the Commonwealth Government was prepared to grant financial assistance to the Tasmanian Government in accordance with the terms of the *Hospital Benefits Act, 1945-1947*, provided agreement was reached between the Tasmanian Government and the Council of the Tasmanian Branch of the British Medical Association that visiting doctors would serve at the rate of remuneration obtaining in Brisbane. The General Secretary said that he had sent the letter to the Branches. The Queensland Branch replied that the arrangements obtaining in Brisbane were a compromise and that in its opinion the Tasmanian Branch should ask for a higher rate together with some provision for sick leave and additional payment for extra work. The Western Australian Branch thought that the sum offered was inadequate and that the fee for each session should be five guineas. The New South Wales Branch in its reply emphasized its adherence to the honorary system and referred to the custom prevalent in New South Wales of classifying hospital patients into public, intermediate and private groups. The Victorian Branch left the matter in the hands of its delegates and the South Australian Branch was content to leave the matter to the decision of the Federal Council. Dr. J. L. Grove pointed out that the Tasmanian Government was agreeable to the payment of a higher rate than that suggested by the Federal Minister, but that the Commonwealth Government was the stumbling block. The General Secretary drew attention to the fact that the remuneration of specialists had been discussed in England in the Spens Report, recently published. Dr. A. J. Collins thought that the Federal Council should advocate a sessional fee of five guineas. The Commonwealth Government wished to take over the administration of all hospitals and this would be bad for the profession. He moved that, without prejudice to its attitude towards the future hospital policy of the Association in Australia as a whole, the Federal Council was of opinion that visiting medical officers in Tasmanian hospitals should be paid a minimum of five guineas per session of three hours. The motion was seconded by Dr. W. F. Simmons, who pointed out that the Commonwealth Government had allotted the sum of £500,000 for the payment of hospital staffs throughout Australia. He thought that if a larger fee than that suggested by the Government was paid, the result would be a cutting down of the number of practitioners on hospital staffs. Dr. F. W. Carter said that the Commonwealth Government was concerned with the lowest amount of remuneration paid in any State and fixed the amounts paid in that State as suitable for all the other States. Dr. A. E. Lee described some of the negotiations which had taken place in Queensland and expressed the opinion that the Tasmanian Branch should press for greater flexibility and more grades in payment, that they should press for payment of extra sessions at three guineas per session and should ask for two weeks' sick leave on full pay in addition to the other Queensland conditions of remuneration. He pointed out that the Spens Report took no cognizance of the compensatory value of appointment to a hospital staff. Dr. Leigh Cook said that the Spens Report had been compiled in terms of the value of money in 1939 and that because of the change in the value of money since that year the suggested payment of five guineas should be revised. He thought that this might be taken up with the Federal Minister. Dr. H. W. Horn read a short statement explaining the present position in Queensland and Dr. A. J. Collins said that he was amazed at some of the ideas expressed by the Queensland Branch. He said that in the matter of hospital services the profession in Queensland had been sold into bondage. Dr. Collins's motion on being put to the meeting was carried. It was also decided that the services of the General Secretary should be made available to the Tasmanian Branch in their negotiations with the State and Commonwealth Governments in this matter.

#### *The National Health Service Act of Great Britain.*

The General Secretary drew attention to the Spens Report on the remuneration of consultants and specialists and to editorials which had appeared on the subject in the *British Medical Journal* of June 12, 1948, and in *THE MEDICAL JOURNAL OF AUSTRALIA* of August 7, 1948. He also said that he had received from Dr. Charles Hill, Secretary of the Parent Body, a brief account of what had taken place in British medical services during the past year. Copies of this statement had been sent to the Branches and to members of the Federal Council.

#### **Contract Practice.**

##### *Contract Practice Committee.*

The Contract Practice Committee of the Federal Council was reappointed as follows: New South Wales, Dr. H. R. R. Grieve; Queensland, Dr. L. P. Winterbotham; South Australia, Dr. R. J. Verco; Tasmania, Dr. J. R. Robertson; Victoria, Dr. C. H. Dickson; Western Australia, Dr. H. Leigh Cook; together with the President, Sir Henry Newland, *ex officio*.

##### *Victorian Common Form of Agreement.*

Dr. C. Byrne said that a tentative agreement on the lines of the Common Form of Agreement had been drawn up by the Victorian Branch and he asked the Council for its approval of the agreement. The income limit suggested by the lodges was £416, together with £26 for each dependant. The capitation rate was 36s.; widows with dependants were to pay 30s. and single women 24s. *per annum*. Midwifery fees were to be the subject of private arrangement and variations in the capitation rate according to the cost of living index were to be made every three years. It was also thought that all members of lodges whose incomes exceeded the income limit might remain as members, provided they had joined before 1945, and also provided that their income had not risen to a level 50% higher than the figure of the new income limit. Payment for mileage was to be made for distances in excess of two miles. No upper income limit had been mentioned. Dr. W. F. Simmons said that the Federal Council would have to realize that the figure of £364 mentioned in the common form of agreement was too low. In New South Wales a problem existed in respect of the Newcastle area, where a £500 limit was being sought. It was necessary that an upper limit should be stated. If an agreement was reached in regard to an income limit, uniform rates should be established throughout Australia. Dr. Simmons thought that the income limit should vary between £416 and £520. Dr. Leigh Cook thought that a period of three years was too long to wait for variations dependent on the cost of living index. The General Secretary insisted that, if the income limit was varied, the capitation rate would have to be varied as well. Approval was given to the tentative agreement of the Victorian Branch.

##### *South Australian Common Form of Agreement.*

The Federal Council also discussed a proposed common form of agreement for South Australia. It was stated that this agreement did not differ materially from the Federal Common Form of Agreement. The most important point about it was that all reference to an upper income limit was to be omitted. In speaking to this question, Dr. R. J. Verco remarked that if the income limit of the Federal Model Common Form of Agreement was observed there would soon be no eligible lodge patients. Dr. H. R. R. Grieve said that he would like to see approval given to the South Australian agreement. He had always looked on the agreement as setting a standard which was not to be too rigidly observed. In other words, it was to be used with discretion when all other factors were considered. If an exception was made it would not necessarily cut standards. Dr. A. C. Thomas remarked that lodge capitation rates would soon have to be on a non-concessional basis. After lengthy discussion it was resolved that, since the South Australian capitation rate for friendly society lodge practice was based on a unit system, the sum of £500 should be approved as the lower income limit. During the discussion on this agreement, Dr. H. R. R. Grieve thought that the South Australian Branch might be urged to conclude an agreement providing a service for persons whose incomes ranged between £500 and £800 *per annum* with appropriate capitation rate. The President said that it was necessary to recognize that changes were taking place and that it would be impossible to secure agreement between all the Branches. Dr. H. C. Colville said that it was impossible to apply coercion to the States. Uniformity would never be achieved and variations would always exist. Dr. W. F. Simmons said that the suggestion that South Australia should be given *carte blanche* cut across all that the Federal Council had been fighting for during the last eight years. Once the idea got abroad that latitude was to be allowed, it would spread like wildfire. The Federal Council was supposed to act as a coordinating body and it appeared to Dr. Simmons that the profession had come to a parting of the ways on the question of federal unity. On being asked about the provision of an upper income limit, Dr. R. J. Verco said that he could give no assurance for his Branch, but that he would do his best to see that a suitable figure was adopted. The Federal Council then determined that if the South Australian Branch adopted an upper income limit of £552, it would approve of the South Australian agreement.

At this stage, Dr. W. F. Simmons moved that the whole matter of contract practice for people with incomes over those mentioned in the Common Form of Agreement should be referred to the Branches and that at the next meeting of the Federal Council the views of the Branches in regard to appropriate income limits and capitation rates should be considered. The motion was carried.

#### Conditions of Service of Full-Time Officers of the Permanent Armed Forces.

The General Secretary reported that he had received from the Secretary of the Department of the Navy a statement of the conditions of service of medical officers of the Royal Australian Navy. These were set out in tabular form together with certain explanatory remarks. The General Secretary said that the general impression was that the pay for the lower ranking officers was practically equal to that of Commonwealth medical officers, but that of the higher ranks was less. Most of the trouble at present was due to retention in the services against their will of men who had offered for wartime duty. The communication from the department had been sent to the Branches. The New South Wales Branch replied that conditions were still unsatisfactory and the Western Australian Branch had expressed the opinion that all the appointments should be graded according to the positions in the Commonwealth medical services. During discussion it was pointed out that no recruits were forthcoming for the Navy and from this it was argued that the conditions of service should be improved. In regard to retention of officers in the services, men could not be released unless others were appointed to take their places. Those in authority could offer no solution to the problem. Dr. H. C. Colville explained that the Victorian Branch had arranged a conference with the medical heads of the fighting services. From this there was little to report. The situation was exactly as it had been described—there was no solution. The heads of the services were seized with the position. They were trying to put the two years' service on a firm basis and were trying to provide better post-graduate facilities. One method of recruiting that had been suggested was that comment might be made on the subject in *THE MEDICAL JOURNAL OF AUSTRALIA*. If uniformity in the matter of appointments was achieved, it was thought that the Editor might be asked to deal with the matter. Dr. A. J. Collins asked whether the Navy would be willing to use militia officers. Dr. Victor Hurley said that the problem was difficult. At the conclusion of hostilities in the present war a case had been made out for continuance of the call-up, but the Government had been adamant in its refusal to allow this. In the Navy there were two kinds of appointments. There was the short-term appointment and there was what might be described as a career appointment. In career appointments the need was not so much for a high salary in the earlier stages as for the provision of adequate post-graduate study facilities. It was unfortunate, too, that there were not more senior jobs. If only junior jobs were to be available the service would not be attractive. Dr. Hurley thought that a request should be made for more chances of promotion for those holding career appointments. If militia officers were used, many of them would be placed in jobs carrying clinical experience. This would mean that there would be still less chance of clinical experience than at present for those in career jobs. There should also be a regular rotation of jobs in the services. The Federal Council resolved that if and when conditions of service of medical officers in all three services were determined, a request should be made to *THE MEDICAL JOURNAL OF AUSTRALIA* for their publication in the news section of the journal. The Council also resolved that a further communication should be sent to the Minister for the Navy stating that the Federal Council was of the opinion that, in order to attract more medical officers to the Royal Australian Navy, it would be necessary: (a) to improve conditions of service to provide better opportunities for promotion for those medical officers who wished to make the Navy a career; (b) to give an undertaking that officers on short-term service would be released at the end of the period for which they had enlisted; (c) to provide further opportunities for post-graduate study; (d) to facilitate the release of medical officers now being forced to remain in the services by inviting a sufficient number of graduates under a contractual obligation to the Commonwealth Government to enlist in the Royal Australian Navy; (e) to improve the present inadequate salaries of senior medical officers.

#### Life Assurance.

The General Secretary reported that after the last meeting of the Federal Council he had written to the Life Officers'

Association for Australasia asking that the fee payable for a report by a medical practitioner without examination of the patient be increased from ten shillings and sixpence to one guinea. He had received a reply in which it was stated that a fee of one guinea would be reasonable.

A request was received from the Western Australian Branch for information regarding the steps taken to implement the Federal Council's decision that the fee for the standardized medical examination for life assurance should be two guineas. The General Secretary said that he had written to the Life Officers' Association and had received a reply to the effect that as the information required in the form had been cut down, it was thought that the work of medical practitioners would be reduced and that the present fee of one guinea would be adequate. This view was not accepted and it was decided to communicate with the Life Officers' Association again.

#### Medical Examination for Pilot's Licence for Aircraft.

The General Secretary reported that he had written to the Director-General of Civil Aviation in regard to the fees payable for the medical examination of members of flight crews. In this letter he had suggested that the fees should be increased. He had received a reply in which it was agreed that there should be some upward revision of fees. The proposal was that the fee should be the same for all examinations (one and a half guineas) except for the examination of commercial and airline transport pilots for whose examination fees of one and a half guineas and two guineas respectively were suggested. The letter had been sent to the Branches and the opinion had been expressed that no decision should be made until new forms, which were to be introduced, had been received. Decision was deferred.

#### Fee for the Examination of Entrants into the Royal Australian Navy.

The General Secretary read a letter which he had received from the Queensland Branch in reference to the fee paid for the examination of entrants into the Royal Australian Navy. With the letter was enclosed a form which had to be completed during the examination. For this work the medical officer received a fee of half a guinea. The Queensland Branch thought the fee was inadequate. The letter had been referred to the Branches. After the replies from the Branches had been read, Dr. H. W. Horn, who described the completion of this form as an onerous task, moved that a fee of two guineas should be paid. The motion, which was seconded by Dr. T. Giblin, on being put to the meeting was lost. Dr. Victor Hurley proposed and Dr. W. F. Simmons seconded a motion to the effect that the fee should be £1 11s. 6d. The motion was carried.

#### Unemployment and Sickness Benefits Act.

At previous meetings of the Federal Council the *Unemployment and Sickness Benefits Act, 1944*, had been discussed and exception had been taken to the request by the Department of Social Services for disclosure of information about patients when the consent of the person concerned had not previously been obtained. The Federal Council held that to give information about a patient in these circumstances was a betrayal of the patient's confidence. At the previous meeting of the Federal Council it was resolved that the Department of Social Services should again be written to with a request that the patient's authority for disclosure of information should always accompany the department's request. It was also resolved that a request should be made to the department for the payment of a fee of ten shillings for any information given.

The General Secretary reported that he had written to the department again and had received a reply from the Director-General of Social Services, in which it was pointed out that loss of benefit would be suffered by the claimant unless he was able to substantiate his claim within a certain period. The Director-General pointed out that full acceptance of the Federal Council's views would tend to delay the determination of claims for benefit. In the Federal Council's letter to the department reference had been made to the manner in which a particular request had been made by the department to a New South Wales practitioner. The Director-General, in his reply, stated that instructions would be issued immediately, that requests for information should be made by letter, setting out the whole of the circumstances and explaining the reason. Officers would also be advised that where a doctor expressed such a desire the claimant's authority should first be obtained. If the requirement of a written authority was to become the rule rather than the

exception, it seemed that claimants would have to be held responsible for obtaining from doctors the information required by law to support an application for arrears. In regard to the request for a fee of ten shillings, the Director-General stated that where a special examination and report were required by his department, payment of the usual fee would be authorized. In most cases, however, the officers of the department were merely acting on behalf of the claimant, whose responsibility it was to furnish whatever medical evidence was required to support the claim for benefit. In such cases it would not be possible to authorize payment to a medical practitioner. The General Secretary reported that the Director-General's letter had been sent to the Branches and that replies had been received. It was resolved that the Federal Council should reaffirm its previous decision that no information should be furnished without the patient's written consent and that where the Department of Social Services sought the information a fee of ten shillings should be paid by the department.

#### The Salaries of State Government Medical Officers.

A letter was received from the Western Australian Branch protesting against an advertisement from the Department of Health of Victoria, which had appeared in THE MEDICAL JOURNAL OF AUSTRALIA of March 20, 1948, as it considered that the salary offered was inadequate. The position advertised was that of tuberculosis officer to the General Health Board of the Department of Health of Victoria. During discussion it was pointed out that there was considerable variation in the salaries of departmental medical officers in the several States. Those in Victoria were, generally speaking, low. It was suggested that the salaries offered to government medical officers should be reviewed and that an effort should be made to produce something like uniformity. The Federal Council resolved that in its opinion the minimum salary for the position of tuberculosis officer to the General Board of Health of Victoria should be £1250 per annum. It was also resolved that the salaries of medical officers employed full time in government medical services should be reviewed and also that they should be referred to the Branches for consideration.

#### Ships' Surgeons.

The General Secretary reported that in accordance with a decision of the Federal Council, he had written to the Australasian Steamship Owners' Federation asking that consideration should be given to an increase of the fees paid by saloon passengers of ships to the following rates: first saloon passengers, ten shillings and sixpence a visit; second saloon passengers, seven shillings and sixpence per visit; and third saloon passengers, five shillings per visit. It was also pointed out that although the ship's surgeon was paid a salary, the amount of the salary was small in comparison with the usual rates of payment made to medical practitioners and that the extra amount received by the ship's surgeon for attendance on passengers did not bring his income up to an adequate amount. The General Secretary said that a reply had been received from the federation agreeing that the amount suggested by the Federal Council should be paid.

#### The Importation of American Medical Publications.

A letter was received from the Tasmanian Branch asking for verification of a report that the importation of American publications was allowable. A letter was also received from the Victorian Branch, drawing attention to a statement attributed to the Prime Minister that there was no restriction on the importation of educational books from dollar countries and asking for confirmation. The General Secretary said that he had written to the Minister for Trade and Customs, asking what was the present position in regard to the importation of such books and publications. The Minister had replied that the dollar allocations for the first licensing quarter of 1948-1949 had been determined and that book importers might use the allocations for the importation of important books such as those in which the Federal Council was interested. The General Secretary also said that he had received information from a well-known firm of booksellers that any medical book could now be imported. It was expected that it would be possible to supply 80% of the normal requirements of medical books.

#### Customs Duties on Motor-Cars Imported into Australia.

The General Secretary brought to the notice of the Federal Council a letter from the Department of Trade and Customs which had been received by the Victorian Branch as a result of its inquiries into the customs duties payable on motor-cars

*et cetera* imported into Australia. The letter dealt with a passenger's personal effects and set out the conditions to be satisfied before a second-hand motor-car could be included among a passenger's personal effects. Appended to the letter was a statement showing the duties payable on the component parts of completely assembled motor-cars of United States origin.

#### Supplies of Rice.

At the instance of the Western Australian Branch, the Federal Council again considered the question of supplies of rice. This subject had been discussed at many previous meetings of the Council. At the meeting of the Council in March, 1948, it was resolved that the Department of Commerce and Agriculture should be informed that supplies of rice should be made available only to persons suffering from proved allergy to wheat and other cereals. It was now pointed out that as a result of recent research rice had been found to be suitable for patients suffering from hypertension. It was resolved after discussion that the Department of Commerce and Agriculture should be asked to facilitate the supply of rice to patients suffering from hypertension who produced a certificate from a legally qualified medical practitioner.

#### Blood Transfusion.

At the previous meeting of the Federal Council consideration was given to a letter from the Australian Red Cross Society in regard to the fees charged for blood transfusion. It was pointed out that variation in fees charged in the different parts of Australia caused a loss of donors. The Federal Council decided at the previous meeting to inform the Australian Red Cross Society that the standard fee for blood transfusion, when the blood was supplied free by the society, should be five guineas, and that the fee for typing should be one guinea. The General Secretary reported that he had received a letter from the Australian Red Cross Society expressing appreciation of the Federal Council's decision and asking for any assistance that the members of the British Medical Association could give in helping to strengthen the donor panels throughout Australia.

#### Streptomycin.

The General Secretary read a letter from Dr. W. F. Simmons, the Federal Council's representative on the National Health and Medical Research Council, which he had forwarded to the Branches. In this letter Dr. Simmons reported that the Streptomycin Committee of the National Health and Medical Research Council had recommended to the council that the ban on the importation and distribution of streptomycin should be lifted and that practitioners should be advised that a standard dosage producing the optimal therapeutic effect with the minimal side effects had been determined. Dr. Simmons added that the National Health and Medical Research Council had recommended to the Minister that appropriate action should be taken to lift restrictions on the free use of streptomycin and to place it under a control similar to that in existence for penicillin. The correspondence was noted.

#### A Film Showing Convulsive Shock Therapy.

The Federal Council had before it a letter from the Queensland Branch drawing attention to a film that had been shown in Queensland depicting the administration of convulsive shock therapy to a psychotic patient. The film had been brought to the notice of the Queensland Branch by Professor John Bostock, who held that the public showing of such a film was not in the public interest. He thought that it would frighten members of the general public and make many persons unwilling to undergo this therapy when their clinical condition made it advisable for them to have it. The General Secretary said that he had sent the letter to the Branches and that the replies were all in accord with the views expressed by Professor Bostock. The Federal Council resolved that the matter should be taken up with the Commonwealth Film Censor.

#### Proprietary Medicines Investigation Committee.

The General Secretary said that he had received from the Victorian Branch a letter drawing attention to an advertisement which had appeared in a Melbourne newspaper setting out the claims for a certain proprietary medicament. The matter had been brought to the notice of Dr. A. J. Collins, the Federal Council's representative on the Proprietary Medicines Investigation Committee. Dr. Collins reported that he had brought the matter before the committee and that he had received a promise that something would be done.

UNIVERSITY OF MICHIGAN LIBRARIES



### The National Society for the Prevention of Blindness.

The General Secretary reported that he had received from the Commonwealth Health Department a copy of the programme for a conference of the National Society for the Prevention of Blindness to be held at Minneapolis, Minnesota, in the United States, on April 5 to 11, 1948.

### Repatriation Commission.

#### *Fee for Reports on Ex-Service Personnel.*

At the previous meeting of the Federal Council attention was drawn to the inadequate fee of ten shillings that was paid by the Repatriation Commission for reports from medical practitioners on ex-service personnel and it was resolved that the Repatriation Commission should be asked to increase the fee to one guinea. The General Secretary reported that he had written to the commission and had received a reply from the chairman stating that consideration had been given to the Federal Council's letter. The chairman stated that whilst it was recognized that the fee of ten shillings was not a fee for professional skill, it was felt that such payment was more or less agreed to by the majority of members of the medical profession as some recompense to a doctor for the time spent in the compilation of notes which were on hand, to attempt to assist a discharged member of the forces in showing for the purposes of a war pension application that there had been continuity of ill health since his discharge from the forces. The commission held the view therefore that payment of a fee of ten shillings was adequate recompense and regretted that in the circumstances it could not agree to any variation. The Federal Council resolved that the reply was unsatisfactory and that further representations should be made to the Repatriation Commission for an increase in the fee from ten shillings to one guinea.

#### *Fees Paid to Visiting Specialists at Repatriation Hospitals.*

At the previous meeting of the Federal Council a discussion took place on the terms and conditions of the service of visiting specialists to repatriation hospitals. From the information available on that occasion, it was clear that the rates paid in different States showed some variation and that in several instances they were thought to be inadequate. In some cases a salary was paid and in others payments were made on a sessional basis. It was resolved on that occasion that consideration should be deferred until further information was available to the Branches. The General Secretary drew attention to a detailed statement of the remuneration paid in the several States and the matter was discussed at length. It was resolved that in the opinion of the Federal Council the rates in those repatriation hospitals where payment was made on a sessional basis should be as follows: for a session up to two hours, four guineas; for a session up to three hours, five guineas.

#### *The Treatment of War Widows in Repatriation Hospitals.*

The General Secretary reported that he had written to the chairman of the Repatriation Commission in regard to the treatment of war widows and their dependants in repatriation hospitals. He asked whether war widows were entitled to the free choice of doctor and if not whether they were treated by members of the visiting medical staff. The chairman had replied that war widows admitted to repatriation medical institutions were not entitled to a free choice of doctor and that their treatment was carried out by both full-time and visiting medical officers of the hospitals concerned. In the discussion the view was expressed that it would be impossible for war widows in the Repatriation Department's institutions to be attended by practitioners of their choice who were not members of the staffs of the institutions. An added argument in favour of this view was the fact that in one State the repatriation hospital was shortly to become a teaching hospital. The General Secretary read the replies received from the Branches in connexion with this matter and the Federal Council resolved that the Repatriation Commission should be asked to allow war widows to have the free choice of doctor from among members of the visiting staffs of repatriation hospitals.

#### *Taxation on the Expenses of Post-Graduate Study.*

The Federal Council had before it a letter from the Western Australian Branch dealing with taxation on the expenses of medical practitioners engaged in post-graduate study. The present position was stated shortly as follows. A practitioner might undertake a refresher course, and if he did so the Commissioner for Taxation would allow reasonable expenses as taxation rebates on the ground that this expenditure was made in order to maintain efficiency.

If, however, after a course of post-graduate study a practitioner obtained a senior degree or diploma, no taxation concessions would be allowed, since it was held that he had gained a capital asset. In the first case, a practitioner might have a good holiday at the Commissioner's expense while he did a minimum of academic work to save his conscience. On the other hand, the taking of a higher degree or diploma was the best form of refresher course and would be proof that good use had been made of any taxation concessions granted. It was held that the present attitude of the Taxation Department amounted to a taxation of knowledge and placed those who had no financial resources other than professional income at a disadvantage, as compared with their more fortunate colleagues. The Federal Council resolved to make representations to the Federal Treasurer on the matter.

### Ophthalmological Society of Australia (British Medical Association).

A letter was received from the Ophthalmological Society of Australia (British Medical Association) requesting that Dr. A. J. Collins and Dr. Mervyn Archdall should be asked to investigate while they were in England (a) the relations of ophthalmologists to opticians under the National Health Scheme in England, and (b) the attitude of the British Medical Association in England to the medical auxiliary and the nature of the auxiliary approved by the British Medical Association. The request was approved.

### Greetings to the New Zealand Branch.

Dr. E. H. Luke, Chairman of Council of the New Zealand Branch, who was visiting Perth, was asked to convey to the New Zealand Branch the greetings of the Federal Council.

### Illness of Dr. N. M. Cuthbert.

The Federal Council passed a motion of sympathy with Dr. N. M. Cuthbert in his illness and of best wishes for his speedy recovery.

### Votes of Thanks.

The Federal Council passed a vote of thanks to the Senate of the University of Western Australia for having allowed the Federal Council the use of its Senate Room. A vote of thanks was passed to Sir Henry Newland for presiding over the meeting, and the Federal Council also thanked the Western Australian Branch for its hospitality and for the use of its office, and Dr. F. W. Carter and Dr. and Mrs. N. M. Cuthbert for their hospitality.

### Date and Place of Next Meeting.

The determination of the date and place of the next meeting was left in the hands of the President.

## Correspondence.

### AN ADVENTURE IN IMPORTATION.

SIR: For some years the use of BCG vaccine has been discussed by workers in tuberculosis, and in 1947 the honorary staff of the Royal Melbourne Hospital recommended that protection should be afforded to all Mantoux-negative trainee nurses who might desire it if vaccine could be obtained. It was known that the Commonwealth Serum Laboratories were planning production, but that it would be some time before it could be undertaken. The matter was discussed by members of the medical staff of the Victorian Department of Health, and the merits and disadvantages of the use of the vaccine received careful consideration. It was decided that if supplies could be obtained, the following classes of persons at special risk should be offered protection, namely, members of nursing and domestic staffs at all sanatoria and public hospitals and private hospitals which are training schools, as well as all medical and dental students. It was considered that later its use might be extended to young children who are contacts of open cases.

The State Government adopted the department's recommendation and made available £1000 for the purpose. The following account of the use made of this appropriation is published for the information of medical officers of health and workers in tuberculosis. Inquiry was first made from Dr. H. Ferguson, of Saskatchewan, whose results in immunization of nurses in the past ten years have been very encouraging. Through him the department's officers were put in touch with Dr. Armand Frappier, Director of the

Institute of Microbiology and Hygiene, University of Montreal. He was asked to advise as to the viability of the vaccine, and the possibility of forwarding supplies from Montreal to Melbourne.

Several difficulties were at once apparent. The life of the vaccine is at the best only eleven days, and the journey by air takes at least six. This leaves very little time for distribution and use. Although the air mail service via San Francisco is frequent, adoption of this route entailed passage through three postal services; on the other hand the service via Vancouver was not convenient, in that the weekly plane arrived in Melbourne on a Thursday. However, inquiries from the postal authorities who were most cooperative and helpful showed that once a fortnight there is a plane from Vancouver which arrives in Melbourne on a Monday, a far more suitable day.

After an interchange of cables with Dr. Frappier, the latter decided to forward a dummy package, representing a consignment of 125 doses in 25 ampoules. It was at this point that the postal and the customs officers were most helpful. Advice concerning the procedure in obtaining an import licence was given, and arrangements were made that there should be no delays at the port of entry. The package was carefully kept in view at the point of transshipment in Sydney. In due course the dummy package arrived safely, having taken just six days, as did a second dummy package sent by Dr. Frappier.

Arrangements were then made for the necessary dollars. This, and the import licence, entailed a considerable amount of clerical work, which was undertaken by one of the department's inspectors. In the meantime the medical superintendents of the Royal Melbourne and the Alfred Hospitals had undertaken the Mantoux testing of their nursing staffs, and an order was sent for sufficient BCG to vaccinate the Mantoux negatives at the Royal Melbourne Hospital. As the mail containing the package arrived at 7.30 in the evening, delivery was taken by a medical officer of the department, and the precious package handed over to an accredited messenger from the hospital. The second consignment was made available to the Alfred Hospital. Other hospitals were then offered supplies, and a larger consignment ordered, but on this occasion the package failed to arrive before the expiry date. Eight consignments, over 2000 doses in all, have been imported, and only this one consignment was lost from this cause, though a later consignment of 720 doses caused some anxiety, as it did not arrive until Thursday, leaving only forty-eight hours available for distribution and use before the expiry date. It was found that this package had been sent across Canada, from Montreal to Vancouver by train, the reason being that owing to a severe blizzard all transcontinental planes had been grounded for two days.

After supplies had been made available to all the sanatoria and training schools in the metropolitan area, and to the three provincial hospitals, the large country hospitals were circularized and informed of the possibility of providing them with the vaccine, and the steps which should be taken before requesting supplies. Replies were received from ten of the twenty-one hospitals communicated with, and of these nine indicated their desire to take advantage of the department's offer. The distribution of the vaccine to some of these called for careful planning; the vaccine was sent by rail to six (Mooroopna, Horsham, Stawell, Warrnambool, Wangaratta and Maryborough) and by air to three (Hamilton, Swan Hill and Mildura). Assistance was given by the Victorian Branch of the Red Cross Society, which undertook the distribution of vaccine by road to Bairnsdale.

An ampoule or two from each consignment was used for control testing, either at the University Laboratory, the Walter and Eliza Hall Institute, or the Baker Institute. Some of the vaccine from the consignment which arrived after its expiry date was also cultured, and all specimens showed that the vaccine had survived the vicissitudes of the voyage across Canada and through the tropics. No special precautions as regards temperature changes were taken; each consignment travelled as an ordinary postal package.

The method advised by Dr. Frappier, that is, two intradermal injections of 0.1 millilitre about an inch apart in arm or thigh, was used. Excluding one particular hospital where the rate was inexplicably low, the conversion rate of those retested is 86%.

Very few unpleasant reactions have been reported. Of these there appear to have been three varieties: (a) mild local "cold abscesses" which have resolved within a week or two; (b) one large "cold abscess" about one and a half to two inches in diameter which broke down and healed completely within four weeks; (c) a few cases were accompanied by a slight general reaction.

The results obtained up to date are considered to be sufficiently encouraging to justify continuance, and further

supplies will be imported as required until such time as they can be obtained from the Commonwealth Serum Laboratories.

Yours, etc.,

E. R. H. EBBs,  
Acting Secretary, General  
Health Branch.

Department of Health,  
295, Queen Street,  
Melbourne.

September 1, 1948.

## Naval, Military and Air Force.

### APPOINTMENTS.

THE undermentioned appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Number 130, of September 2, 1948.

#### ROYAL AUSTRALIAN AIR FORCE.

##### Citizen Air Force: Medical Branch.

The appointment of Temporary Squadron Leader J. J. Nattrass (257665) is terminated on demobilization, 3rd August, 1948.

## Obituary.

### FRANCIS EDWARD MCAREE.

WE are indebted to Dr. A. McQueen Thomson for the following information concerning Dr. Francis Edward McAree.

Dr. Francis Edward McAree, son of Dr. Francis McAree, a staff surgeon of the Royal Navy, graduated from the University of Adelaide in 1906. He was an honorary physician to out-patients at Saint Vincent's Hospital, Melbourne, and secretary of the honorary staff for some time. During the 1939-1945 war years he was honorary physician to Prince Henry's Hospital, Melbourne. He carried on a general practice in Middle Park for about thirty-five years and was anaesthetist for Sir Hugh Devine and Dr. Murray Morton.

Dr. McAree was loved and admired by all his patients as the best type of family physician and all who knew him respected him as a Christian gentleman. He carried out extensive work for the Saint John Ambulance Association in first aid, particularly in association with the railways, both teaching and examining; he was appointed a life member in 1916 and an officer in 1936. He was the secretary of the South Central Subdivision of the Victorian Branch of the British Medical Association for many years and its representative on the Branch Council. His hobbies were tennis, football and cricket. He was a great traveller and had an intense love of ships and everything connected with them, which furnished him with a vast fund of most delightful and unexpected stories.

Apart from the practice of medicine, he found his life's work and ambition in the support of charity. It has been truly said of him that no one ever came to him for help and went away empty-handed. He gave abundantly and continuously to both hospitals and his church, but above all, possibly because he never married and produced his own children, he gave most lavishly and with keenest joy and interest to the care and education of the young.

Dr. Murray Morton writes: Over many years of my active surgical practice I came to know and appreciate the many qualities of Dr. F. E. McAree as a general practitioner. Our first association was as members of the honorary staff of Saint Vincent's Hospital. For several years Dr. McAree was a physician to out-patients and also for a time anaesthetist in my clinic. In both capacities his work was thorough and conscientious. He sent much of the surgical work in his general practice to my care and I was always impressed by his interest in the welfare of his patient which did not cease when the treatment passed into other hands. In my opinion, Dr. McAree was the ideal careful, conscientious and self-denying general practitioner, who never deviated from the highest ethical standard of his profession.

Dr. R. D. Aitchison writes: Over thirty years ago I remember my father telling me that Dr. McAree had commenced practice at Middle Park. The outstanding memory of that conversation was the manner in which he stressed the kindness of the newcomer. Later, when I came home and commenced practice in Albert Park in 1919, one of the first to greet me and wish me well was the same Dr. McAree. He did all he could to help me bridge the transition into private practice, helping me with his advice and practical help. From this beginning and throughout the ensuing thirty years I found that my father's opinion was correct. I am happy to acknowledge publicly the debt I owe to him. He was one of the older group of practitioners full of the ideals of his profession—his relationship to his colleagues and his duty to his patients. He will be sorely missed by his colleagues to whom he gave valued service and guidance as secretary and member of Council for so many years. He will also be sadly missed by a large body of patients to whom he gave of his best.

Dr. John O'Donoghue writes: The late Dr. Francis McAree was a particularly sound and painstaking physician, whose code of ethics was one of which any one of us could be justly proud, but perhaps the extent of his charity is not widely known. It was in this field that he accomplished so much and spoke so little of it, and to those numerous organizations who have benefited from his help, his passing is indeed a great blow. His naturally retiring disposition and lack of desire for prominence caused him to remain in the background except to those with whom he came into contact frequently. To a manner which at times may have seemed somewhat abrupt was allied a dry but none the less delightful sense of humour and quick-wittedness, much appreciated by those of us who knew him. A man profoundly admired and respected by his patients, the death of Dr. Francis McAree has taken from the medical profession in this city one of its most conscientious and devoted members.

#### HAROLD DAVID BOWYER MILLER.

We regret to announce the death of Dr. Harold David Bowyer Miller, which occurred on August 31, 1948, at Melbourne.

#### THOMAS WILSON TASSIE.

We regret to announce the death of Dr. Thomas Wilson Tassie, which occurred on September 1, 1948, at Adelaide.

#### JOHN SYDNEY GREEN.

We regret to announce the death of Dr. John Sydney Green, which occurred on September 4, 1948, at Melbourne.

### Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Kennedy, Thomas Andrew Knox, provisional registration, 1948 (Univ. Sydney), 11, Church Street, Pymble.  
McGirr, Gwendoline Frances, M.B., B.S., 1943 (Univ. Sydney), 81, Ranger's Avenue, Cremorne.

Treloar, Douglas Tremayne, provisional registration, 1948 (Univ. Sydney), 22, Park Crescent, Pymble.

Reynolds, Farrell John, provisional registration, 1948 (Univ. Sydney), Royal North Shore Hospital, St. Leonards.

### University Intelligence.

#### UNIVERSITY OF MELBOURNE.

A LECTURE by Alice Barber, M.B., B.S., D.P.M., part-time lecturer in the departments of psychology and social studies, on "Some Uses of Drawing in Psychopathological

States", illustrated with slides, some in colour, will be given in the Lecture Theatre, Engineering School, University of Melbourne, on Monday, September 27, 1948, at 8.15 p.m. The chairman is Professor P. MacCallum, Professor of Pathology.

### Diary for the Month.

- SEPT. 21.—New South Wales Branch, B.M.A.: Medical Politics Committee.  
SEPT. 22.—Victorian Branch, B.M.A.: Council Meeting.  
SEPT. 23.—New South Wales Branch, B.M.A.: Clinical Meeting.  
SEPT. 24.—Queensland Branch, B.M.A.: Council Meeting.  
SEPT. 28.—New South Wales Branch, B.M.A.: Ethics Committee.  
SEPT. 30.—New South Wales Branch, B.M.A.: Branch Meeting.  
OCT. 1.—New South Wales Branch, B.M.A.: Annual (1948) Meeting of Delegates.  
OCT. 1.—Queensland Branch, B.M.A.: Branch Meeting.

### Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

**New South Wales Branch** (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phoenix Mutual Provident Society.

**Victorian Branch** (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federal Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

**Queensland Branch** (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute, Bundaberg Medical Institute; Brisbane City Council (Medical Officer of Health). Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

**South Australian Branch** (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

**Western Australian Branch** (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

### Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2.)

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